VOLUME I - NUMBER 5 SEPTEMBER - OCTOBER 1960

PSYCHOSOMATICS

OFFICIAL PUBLICATION
OF THE
ACADEMY
OF
PSYCHOSOMATIC
MEDICINE

A
JOURNAL
EXPLORING
THE ROLE OF
PSYCHIATRY
IN THE
DAILY
PRACTICE
OF
TOTAL
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PSYCHOSOMATICS

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Contents

whenever depression complicates the picture

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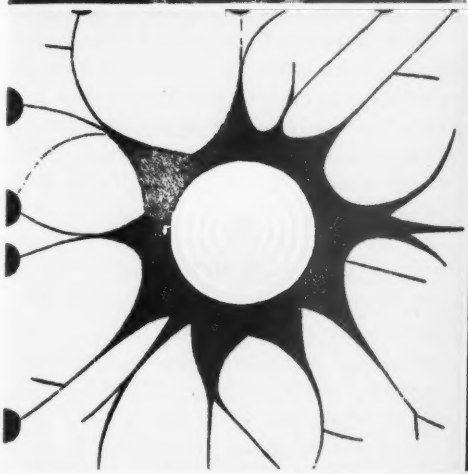

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Editorials

Comprehensive Medicine

The lead article in this issue of *Psychosomatics* is "The Contribution of the Psychiatrist to the Comprehensive Approach in Medicine." In it, Drs. Hoffman, Steiger and Magran point up the challenge that has been created by the influence of psychiatry on the teaching and practice of clinical medicine.

It is interesting to note the authors' belief that the physician of today is better equipped to practice comprehensive medicine than was the doctor of the horse and buggy days. A statement such as this may sound like heresy, but is unquestionably true when considered in light of the many advances that have occurred not only in dynamic psychiatry but in bacteriology, biochemistry, physiology and clinical medicine.

The teaching approach to comprehensive medicine at Temple University Medical Center is indeed unusual, since it is an "equal partnership of medicine and psychiatry . . . where the internists teach the psychiatrists and the psychiatrists teach the internists. . . ." One might also add that the students also play a definite role in that they aid not only in the postgraduate education but also in the maturation of both internists and psychiatrists. This setting at Temple is remarkable, since the usual state of affairs is that the student learns clinical medicine from the internists, and psychiatry from the psychiatrists, and is only rarely exposed to a compatible, comprehensible mixture of both. In a truly comprehensive setting, the presystolic rumble of mitral stenosis, or the deleterious effects of a one celled, invisible filtrable virus are not necessarily more or less important than the rumpus that can be created by a multi-cellular mother-in-law, who is not only visible and audible, but has infiltrated the entire household and shows suspicious signs of metastasis to the master bedroom.

The authors consider the contributions of the psychiatrist and his role in a Comprehensive Clinic. It would be interesting indeed if they would follow this up with a consideration of the role of the non-psychiatrist in this setting. Only then can the entire picture become clarified.

"Psychosomatic Medicine" has many facets and many uncharted areas that need exploration. It is through the efforts of a multi-disciplined approach such as the one at Temple University, that some of the conflicts, dilemmas and enigmas can become understandable.

The Editor is grateful to the authors for the opportunity to publish this most challenging review, and hopes that it will be followed by other contributions from Temple University and other centers where Comprehensive Medicine is taught, thought and practiced.

A Reply

A recent editorial in *Medical Science* Sept. 10, 1960 (reprinted below) entitled "Treating the Patient as a Hole," is apparently not a misprint, but represents the author's protest to the concept of comprehensive medicine, where the patient is treated as a "whole." Unfortunately, the actual facts of the matter are distorted beyond recognition. Comprehensive medicine does not take a stand against the proper and intelligent use of laboratory tests or roentgenographic studies. It is not against scientific investigations and does not suggest that these studies have "dehumanized" medicine. Comprehensive medicine does not "start with the assumption that all patients with diabetes mellitus must have a serious emotional disturbance, that requires meticulous investigation and intensive treatment." What it does assume is that the intelligent and well trained physician, when faced with a refractory, extremely labile diabetic, should search for the possible hidden in-

fection, hormonal or emotional dysequilibrium which usually lies behind this refractory state. It does make the plea, however, that emotions can be just as significant as other factors and should not be treated like distant second cousins.

There is one final point in the editorial that warrants further consideration: the author's statement that the "ccmpetent physician always treats whatever parts need treatment after studying all of them." One can only wonder how this can be possible when a severe blind spot (even scotoma can scintillate) eliminates and excommunicates feelings, attitudes and behavior from the "parts" involved. Man is not different from the sum of his parts—perhaps some of these parts cannot as yet be chemically analyzed, as are other more accessible regions, but they nevertheless exist. How can a basic emotion such as anger be classified as "mystical," when well-intentioned medical educators and editors are capable of experiencing it when they fear that comprehensive medicine stands in opposition to the many scientific advances in medicine? This anger is most justified when interpreted in this manner; perhaps when these misconceptions are ventilated and seen to be misconceptions rather than the truth, this feeling (although it cannot be titrated) will be definitely diminished.

W. D.

Treating the Patient as a Hole

Editor's Note: "Treating the Patient as a Hole" appeared as an editorial in the September 10, 1960 issue of *Medical Science* and is reprinted here with the consent of its editor for your possible comments. The philosophy expressed is obviously *not* one that is in complete harmony with the goals of the Academy as the above editorial will indicate.

The introduction of laboratory tests and of mechanical means of examination has had profound effects on the practice of medicine. For one thing, their introduction has always met with some opposition, usually on the basis that their use dehumanized medicine. One authority of a century ago described percussion and auscultation as "a coarse and mechanical means of investigation which a physician with a clear mental vision did not need; it also lowered and debased the patient, who always remained a human being, by treating him as a machine." At most it was considered permissible to employ these methods of examination on ward patients, who obviously were considered a lower form of life than private patients.

Sometimes the opposition took another form: The great Irish clinician, Bullock, stated a century and a quarter ago that medical students should be forbidden the use of the stethoscope entirely because it prevented development of their powers of observation.

Today's criticism of the use of laboratory medicine is stated in exactly the same terms as was that of earlier eras: Reliance on laboratory tests is said to dehumanize medicine and also to dull the powers of observation. Today's suggested remedy is "comprehensive medicine"—treating the patient as a whole. This is usually represented as a way of practicing medicine that is opposed to what is stated to be the usual modern practice, which is to treat the patient as a hole—a hole into which gallons of roentgenographic contrast media and other test substances are poured, a hole from which equally large amounts of blood, juices, urine, etc., are drawn off. This latter view of the practice of medicine is, of course, absurd and its purported remedy, called "comprehensive medicine," is likewise invalid: examination of what is called "comprehensive medicine" reveals that it differs from ordinary medicine in the admixture of a large amount of material derived from currently-fashionable psychiatry and sociology.

There are, undoubtedly, physicians who do not use laboratory data appropriately. This problem cannot be solved either by exhorting physicians to "treat the patient as a whole" or by attempting to persuade them to adopt the vague hypotheses of currently-fashionable psychiatry and sociology. The crux of the matter is that laboratory data when used diagnostically are only confirmatory: there is no substitute for a thorough history and physical examination. These sometimes afford data that conclusively establish a diagnosis in themselves; in other cases they suggest diagnoses that are ruled in or out by laboratory studies. Diagnostic laboratory tests are valueless without a thorough history and physical examination.

On the other hand, the course of some diseases—such as diabetes mellitus—can be followed only by means of tests. However, these tests can never explain deviations from the expected course. For example, a diabetic patient whose disease is not controllable by ordinary means

(Continued on page 288.)

all of these patients have anxiety symptoms;

*but <u>half</u> need an antidepressant, not a tranquilizer

depression–a common problem in office practice...

"It is generally acknowledged that at least 40 to 50 per cent of the patients seen in private practice have emotional problems and that true depressions or depressive equivalents are found in more than half of these." Cooper, J. H.: J. Am. M. Women's A. *14*:988, 1959

anxiety often "masks" underlying depression...

"Although ataractics have a definite place in therapeutics, their use in depressed states is limited, and in many cases even contraindicated. A large number of patients with psychogenic disorders are given ataractics for the relief of anxiety symptoms. Since the anxiety is actually due to depression, the response, if any, is transient and occasionally the patient may become worse...." Hobbs, L. F.: Virginia M. Month. *86*:692, 1959

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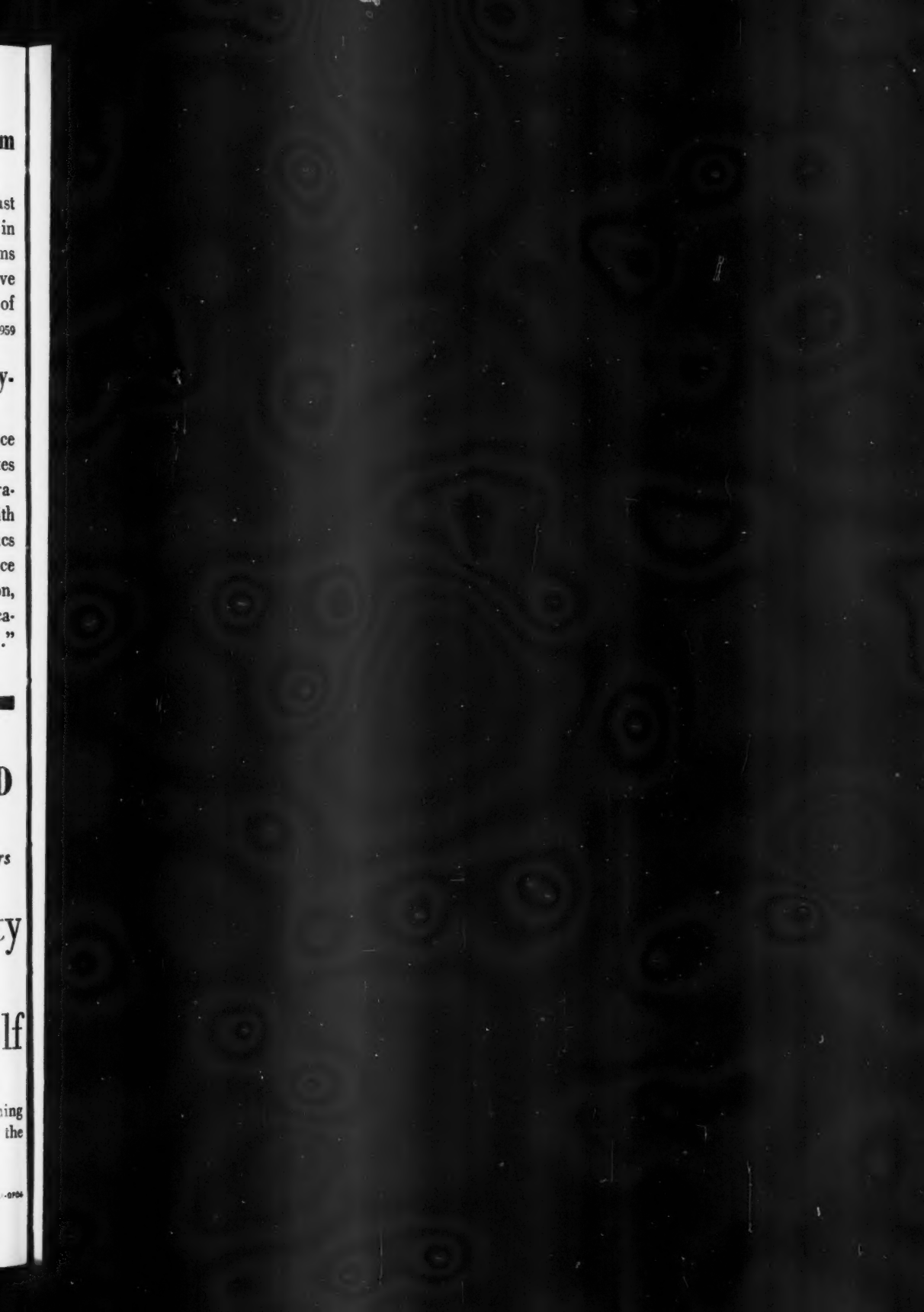

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PSYCHOSOMATICS

Official Journal of The Academy of Psychosomatic Medicine

The Contribution of the Psychiatrist to the Comprehensive Approach in Medicine

FRANCIS H. HOFFMAN, M.D.,* WILLIAM A. STEIGER, M.D.,† and LEONARDO MAGRAN, M.D.‡

Following a recent period of self-satisfaction in medicine, there is now a churning and a ferment that is challenging to many of us. The old patterns of dealing with patients and their problems, while still necessary, are no longer sufficient. Suddenly the knowledge of psychiatry and the investigation of cultures, which have been expanding their influence and worth for understanding man and his illnesses since the beginning of the century, have become fundamental to the practice of medicine.

Today, a patient seeks help from his doctor beyond the alleviation of physical pain. He brings with him the difficulties encountered in dealing with daily chores, associates, family, and self. The physician has always known but not always heeded the fact that man can become sick through forces besides those familiar to everyone, such as anxiety, fear, apprehension of any kind, love, anger, disappointment.[1] Any of the rich variety of human emotional reactions may be detrimental factors affecting not only man's performance but also his biology and, ultimately, his adjustment to the structure of his society.

In this setting of interacting forces, the physician, whether young or old, has come to accept the challenge of treating the individual as a whole, in a complex environment. To achieve this he is more fortunate than the doctor of the past, because he counts now on the contributions that psychiatry has made in the last fifty years or so, some aspects of which are described in this paper.

In the past, medicine emphasized the diseases of man rather than man himself, perhaps for the excellent reason that it had the scientific knowledge and technique which enabled it to treat effectively a large number of diseases.[2] The success of this knowledge may have forestalled the integration into medicine of the later developing psychologic and sociologic knowledge and technique. Our solid pragmatic tradition has led us to seek pharmacologic means of solving problems of man in much the same way as we treat acute infectious processes. We maintain that all treatment is based upon providing the environment in which the individual can utilize to the fullest his recuperative powers and native capacities for flexible adaptation.

The Comprehensive Approach

Throughout the United States, concern with teaching about the whole man—"holistic" or comprehensive medicine—is a growing phenomenon in the medical school

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Read at the Pan-American Medical Congress, Mexico City, May 1960.

curriculum. Yet comprehensive medicine is variously defined. It often means merely a geographic reorganization of biologically oriented specialists so that they meet and practice their skills in the same clinic and upon the same patients. Sometimes other specialists are included, such as social workers and psychiatrists; they are usually in the minority and do not often have a leadership role. In some instances the active ambivalence toward their inclusion in the group is demonstrated by a generous attempt to disguise their area of specialization from the students. A psychiatrist, stethoscope in hand, was introduced in a pediatric clinic as an expert in phonocardiography with the ability to make fine distinctions in the matter of heart murmurs. "Of course," was the amused aside, "he couldn't tell one murmur from the other when he began."

At Temple University Medical Center, comprehensive medicine means an attempt at comprehensive understanding of the patient, in his sociological, biological, and psychological matrix, in order to clarify the reasons for the choice of treatment.[3] It is an equal partnership of medicine and psychiatry in treating, teaching, and learning together with medical students. The internists teach the psychiatrists. The psychiatrists teach the internists. The team shares together with the student the student's role, to reduce the need for dogmatic assertion. We hope to reinforce the student's acknowledgment of his commitment to a continuing role as a student of his patients and their needs.

We want the student to "scan" the field of the patient's reactions to the forces acting upon him, both internal and external, and then select the areas where he, as an individual physician with the resources of his society, can most effectively intervene to relieve the patient's distress. We do not espouse a hierarchy of disease interest. A murmur of mitral stenosis or the edema of heart or kidney decompensation are not valued more or less than the whimper of anxiety or the panic aroused by having to face homosexual thoughts. We are not concerned about where treatment begins in the causal chain of events, but simply that it offers the best opportunity for successful patient management.[4]

Our program now extends through all four years of the medical school curriculum. It began in the fourth year and was gradually extended into each earlier year to solve the problems of giving students a longer time with a particular patient or family; dealing with the anxieties of students moving from basic science to clinical years; and preparing the students in the basic science years to accept and value the pattern of the physician who is concerned with more than the single biologic measure of man. We point out early that man is a unity that can be measured in many ways. The best measure, whether it be biologic, sociologic, or psychologic, is the one that meets the task most adequately: e.g., in diabetes, a blood sugar; in schizophrenia, a psychiatric interview.

Seven years ago we began in the outpatient setting, which was then not highly valued as an area of medical education and was available to anyone who wished to invest the interest and energy in exploring its potential. Outpatient clinics were for many years considered the Siberia of medical education. Unfortunately general practitioners tend also to devalue this area of medical care despite the fact that the greater part of their work is with out-patients. As students, we were taught by specialists who emphasized the importance of hospitalization in order to give the best care to patients, so we are prone to accept ourselves as second class physicians and believe that the "real" activity of medicine that is the biologic measure of man is taking place in the inpatient section of the hospital where patients are being "completely" worked up.

Certainly an important contribution of psychoanalytically oriented psychiatrists

has been in their preference for and high valuation of outpatient treatment. The interview is their primary investigative and therapeutic tool. They see an advantage in the fact that as an out-patient the patient is more himself, relating to his own environment, and less adapted to the role of being a patient in relation to medicine.

Social factors are also increasing the importance of outpatient treatment. Patients with insurance must be expensively hospitalized in order to save money because they are reimbursed for medical care only when hospitalized. There is a growing movement, however, toward construction of hospitals with large out-patient units, smaller ambulatory patient units, and compact, intensive, total care units, for those relatively few patients who need such services.[5] We believe this to be an inevitable development. The structure of hospitalization plans and the role of hospitals must also change. It seems to us that hospitals will become centers for widening the physical and emotional horizons of man rather than places to which one retires in order to facilitate recuperation from severe biological illness.

Personality Patterns, Doctor and Patient

Some centuries ago Galen stated, "He cures most successfully in whom the people have the greatest confidence." For the patient to develop trust, faith and confidence, he must first of all be able to communicate effectively with the physician he has selected, and in turn be understood in his plea for help. To give help, the physician must be endowed with the sympathetic, discerning and perceptive qualities of the healer who looks at his patient's problem not only with scientific curiosity and familiarity with disease patterns, but also with interest and concern for his general welfare and happiness.

This communication, which is basic in the establishment of rapport, is carried out simultaneously at different levels of integration: emotional-intellectual, preverbal-verbal, unconscious-conscious. The physician will acquaint himself with them if he wishes to understand his patient thoroughly. To do this he learns basic principles of dynamic psychiatry which deal with the development and functioning of the normal personality, its deviations and the treatment procedures to correct them.

A patient's attitude toward the physician and to his symptoms will depend to a great extent on his personality. The effects of sickness will be different in a previously well adjusted individual than in one who has shown problems in adaptation throughout life. The well adjusted person will maintain an attitude of objective concern, conscious apprehension, and realistic worry. His judgment will remain adequate and he will be able to look at his problems intelligently and search for a solution with the doctor's assistance. He will follow the physician's recommendations because he relies on his knowledge, but more because he trusts him. He will conform to the limitations created by the disease and will try at the same time to make the necessary arrangements in his life situation called for by the condition.

The patient with an unstable makeup, who has suffered too much anxiety throughout his life, will react differently and in accordance with the pattern of reaction he has developed for dealing with stressful situations. He may become overly anxious, depressed, and despondent; he may deny his sickness altogether or isolate his feelings so that he may act with cold deliberation; he may become exceedingly demanding, possessive, and complaining—he may even seem to enjoy his trouble and welcome whatever painful treatment is used on him. These reactions indicate that the patient is dealing with the anxiety created by his disease using the same mechanisms that he has applied in other situations of distress. This per-

son will react to the disease inappropriately, perhaps even irrationally. He will act toward the physician as if he has lost something of his ability to discern. The physician is, in his mind, not only the skillful practitioner who may help in restoring his health but is also the person who, in his fantasies, should look after him, very much as his parents did in childhood. The physician becomes the recipient of what has been described as "transference feelings," that have to do with infantile longings, anxieties, and frustrations which are no longer appropriate.

Some of the patient's attitudes may reactivate problems of the doctor which have remained unconscious, but are being expressed in the relationship. These unconscious reactions we call countertransference. The physician may lose his objectivity because of this and try to do too much or too little for his patient; he may become easily annoyed at his complaints and impatient to get results; or he may become indifferent and aloof. For this reason, it is important that the psychiatrist teach about dynamic psychiatry in such a way that the student can understand the language of the patient. Bringing the commonplace meanings of connotation and even of pantomime to awareness helps the physician understand unconscious motivations.[6] Psychotherapy for the physician is sometimes necessary, in order to widen his understanding of the unconscious.

Contributions of the Psychiatrist

The psychiatrist's value to the medical student who will become a general practitioner lies in three general areas: 1) as a psychiatric specialist, he diagnoses and treats those patients suffering from psychological disturbances, such as neurosis, psychosis, and character disorders; 2) as a student of personality he contributes to the evaluation of a patient in whom the etiology of disease or the basis of symptoms is obscure, and assists in elucidating those psychogenic factors that may be present and significant, as in many aches and pains, gastrointestinal disturbances, allergies, etc.; 3) in cases where a definite diagnosis of a physical condition has been established he can help in the handling of the patient when personality traits interfere with the treatment, rehabilitation, and adjustment of the patient to his handicaps. These are the usual expectations of psychiatrists and are part of what they can bring to understanding all patients.

His most important contribution in a medical clinic is demonstrating improved techniques of interviewing for his colleagues so that they may learn to unveil the latent content of the material at hand. He not only applies a "third ear" to a patient's productions, but also amplifies the physicians' knowledge of their own reaction patterns to patients. The psychiatrist in a medical clinic must stand ready to deal with the "here and now" of a patient's reactions. Here he is helped by working with internists on a cooperative basis so that he develops an identification with their problems in the treatment of patients. While he teaches the effectiveness of a longitudinal evaluation of the patient's pattern in this situation, he must be ready to commit himself to active intervention on the basis of his "here and now" knowledge. He must be ready to identify the important elements in the present life situation and to communicate, not only what he knows of personality structure and its effect, but also how he knows. He must be ready to demonstrate the effectiveness of his skills in patient management.

He has to take his prognostic risks with other medical practitioners. Unless he knows from his own professional experience the correctness of his impressions and the value of what might appear to be superficial remedial actions, he should not try to teach and work in such a setting. He must stop saying how difficult it is

to reassure and demonstrate how to do it. He cannot fall back upon his own pattern of the intimate one-to-one relationship of psychotherapy but must share his approach to the patient with two or three other people in the examining room. He gives up the protection of waiting for the patient to present all the details of his adaptive pattern and learns to treat patients who are not always ready to accept a view of themselves as being emotionally ill or reacting excessively to their illness. He accepts and promulgates the view that each patient's illness may present an opportunity for evaluation of the patient's past pattern of adaptation and his capacity for alteration and improvement of that pattern. He needs to share his thoughts and intimate feelings with the students and working team so they can see that different degrees of self-understanding are necessary to a clear perception of what is really happening between doctor and patient.[7] He shows that the doctor might not be aware that the patient is acting in a particular way because the doctor is not aware of his feelings toward the patient. If these feelings go undetected, the physician will not be able to decode the message that the patient has been conveying to him.

Once a physician pauses and considers the patient complaining of illness rather than focusing upon the "disease"; once he adopts the attitude of expectant awareness without injecting what he considers the important biologic measure of man; once he frees himself so that he can listen to what the patient is saying that goes beyond the medical phrasing of the complaint—then a wider world of patient need with which he can deal becomes real and important.

Comprehensive Medicine Clinic, Temple Univ. Medical Center is supported in part by The Commonwealth Fund and the National Institute of Mental Health.

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Whatever direction psychosomatic research takes, it is apparent that major advances will require combined psychic and somatic investigation. Since so few individuals are competent in all spheres—clinical medicine, clinical psychiatry and psychoanalysis, biochemistry, neurophysiology—a team approach seems the best hope for a breakthrough. A team can function only with the mutual respect and understanding cooperation of each of its members.

Karl Kay Lewin, M.D.
Psychosomatic Research: Problems in Methodology. *Annals of Internal Medicine*, Vol. 50, No. 1, pg. 122-127, Jan. 1959.

Toxicity of the Mental Drugs — Clinical Aspects

EDWIN DUNLOP, M.D.

Recent years have produced many interesting medications in the field of psychiatry. Until two years ago, a great number of the psychopharmaceuticals had very little effect on depressed states: in fact, many of them, such as the phenothiazine derivatives and the rauwolfia group actually induced depressions if treatment was prolonged.

Stimulating substances have long been in use but have had only a transient effect on depressions and the likelihood of addiction has always been a complication. This is especially so when dealing with amphetamines and allied substances.

In 1957, something entirely new was introduced in the form of Marsilid. This medication, the very first of its kind, was a welcome addition to the scant armamentarium of the psychiatrist in dealing with depressed patients. The earliest published results revealed that a revolution in treatment had occurred. Many gratifying results were seen and the complications regarded as minor, when compared to the major improvement and well-being seen in many patients, who had failed to respond to every known avenue of therapy available at that time.

Many patients of mine, who had failed to respond to two or three courses of electroshock, experienced complete disappearance of their fatigue, apathy, despondency, guilt and other target symptoms of depression. Their speech became louder and more rapid, their facial expressions more animated and many patients on this medication expressed such opinions as, "I have never been so well in many years," and, "I hope I never have to give up this kind of medication." However, several fairly serious complications appeared in my own series. These were hypotension manifested by sudden falling, severe edema, impotence, urinary retention and most dreaded of all, acute hepatitis.

This latter complication brought disrepute to the medication, but a new era had been launched, and many others have now entered this field first pioneered by iproniazid. With the exception of Marsilid which was studied in 1957 and its analogue Marplan which was studied in 1958, the bulk of this work was done during 1959.

The purpose of this paper is to discuss the toxicity of these drugs known as psychic energizers, monoamine oxidase inhibitors, thymoleptics, phrenopraxic agents, or my own appellation "Ergotones" (Ergos = Energy). In this paper I am reviewing the experience of 200 patients treated with currently available antidepressant agents and classify generally my results as follows:

Marsilid

Of 40 patients treated with Marsilid one developed acute hepatitis and another transient jaundice; these were the two most serious complications in my case studies. Both incidentally are now well and fully recovered from their depressions. About 15% suffered blackouts, mainly on first arising in the morning. I had believed this to be due to the intake of Marsilid on arising, but I have not been able to convince myself that a hypotensive reaction has any immediate relationship to the taking of a drug, although the symptoms appeared to be worse early in the morning.

At that time, I gave patients one tablet on arising. I routinely discontinued this morning dose which tended to produce a hypotensive response and found that doubling the dose, either at supper or at

Presented at the Sixth Annual Meeting of the Academy of Psychosomatic Medicine, Cleveland, Ohio, October 1959.

bedtime, did not interfere with sleep, and eliminated the hypotensive reaction the following morning.

Impotence was cause for discontinuance in three male patients. However, when they were switched to other monoamine oxidase inhibitors they also experienced this same problem.

Edema and weight gain were often manifest within 14 to 21 days. This, as a rule, was indicative that a good response could be anticipated. Neuralgic pain, twice trigeminal, twice peripheral, in the lower extremities, was encountered but this complication disappeared with the administration of pyridoxine, 50 mg. b.i.d.

Marplan

With the advent of Marplan, which has assumed the role of "heir apparent" to Marsilid and is endowed with many of the excellent qualities of its progenitors, and in addition is a much more powerful monoamine oxidase inhibitor which has proven substantially less toxic, the treatment of depressions has been greatly enhanced. In over 40 patients studied under the same conditions as Marsilid, Marplan was found to be much less toxic in terms of hypotensive response, edema, weight gain, and impotence. No cases of jaundice were encountered.

An interesting fact presented itself here when five patients who were being maintained on Marsilid were switched to Marplan because of the believed safety of the latter medication. In these patients it did not apparently produce the same response. All five of them requested to be switched back to Marsilid. Three patients out of the 40 experienced jitteriness and overactivity within the first 48 hours. This was so troublesome that they discontinued the medication themselves. This occurred on the recommended dosage of 10 mg. t.i.d. When however, treatment was resumed, a gradual increase of the dosage from 10 mg. daily to 30 mg. over 7 to 10 days eliminated this complication. With its relative safety, Marplan was used on 10 patients with psychoneurotic type problems who presented some obsessive compulsive manifestations associated with fatigue and asthenia. A favorable response was experienced. In none of these 40 patients was the medication discontinued as a lowering of the dosage invariably produced remission of the side effects.

Nardil

In a series exceeding 50 cases, Nardil proved to be the least toxic of all of the monoamine oxidase inhibitors. It was not discontinued for toxic effects in any instance, although the following were experienced:

Constipation	4
Peripheral Neuritis	2
Postural Hypotension	2
Transient Impotence	1
Nausea	1
Rash	1

An atropine-like effect, such as drying of the mouth or warmth throughout the body, was common during the initial stages of treatment but very often disappeared within a week of continued therapy. No evidence of liver damage was observed and no Parkinson-like syndromes were seen.

Catron

The last of the hydrazine derivatives studied was Catron. This drug was found to produce therapeutic benefits as rapidly as any of the other monoamine oxidase inhibitors and in much lesser dosage. Six to twelve mg. daily were sufficient to produce clinical improvement. The complication of edema, hypotensive response and excitation, can be eased quite quickly when maximum doses are reduced.

In terms of toxicity, I have had one patient on this medication for over one year at a daily dosage of 12 mg. who has shown no toxic effects whatsoever. Two liver function tests, having been done at this time, proved essentially normal. Continuing treatment on a patient for

12 months cannot surely be considered a cure but, during the 12 months this patient has gone back to work, has re-established herself in her chosen line of business, has already built a new home for her family and has enjoyed the best year that she has had out of the last 10. This, in my books, is an improvement and one which, incidentally, the patient truly appreciates. I detected no red-green visual defect which apparently has been reported by others.

Tofranil

Tofranil is the last of these five ergotones which we have studied and it is not a hydrazine. The exact mode of action by which imipramine exerts its antidepressant effect is unknown. It does, however, potentiate norepinephrine without inhibiting amine oxidase. In our study of over 60 patients on Tofranil, treated mainly for depressive reactions, the most consistent complaint was that of dryness of the mouth and excessive sweating. The sweating was peculiarly localized to the head and neck. Hypotensive effects were quite rare. None of our patients received over 100 mg. daily and the group did not show any consistent tendency to edema. There was weight gain quite consistently which seemed to be derived from a nutritional benefit and not from retained fluids in the tissues. Several instances of agitation were experienced, but this was generally in a much older group of people. Three of the four experiencing this were 75 or over.

Tofranil has been used in the geriatric group in preference to the monoamine oxidase inhibitors or the four hydrazine compounds described previously. Tofranil has also the advantage of being available for intravenous and extramuscular use if there is patient resistance to swallowing.

SUMMARY

The overwhelming weight of evidence in a multitude of successfully treated patients, points to these drugs as being used more widely and with increasing effectiveness. The problem of toxicity, however, cannot be ignored in spite of this. Recognition and anticipation of any untoward reaction such as has been reported here will undoubtedly help to eliminate or greatly reduce any toxic sequelae and thereby enhance the usefulness of this type of chemotherapy.

In the office patient, and also in the milder hospitalized cases, where due respect is given to this group of drugs in terms of recommended dosage, most gratifying results can generally be obtained within a reasonable period of time.

The comparative lack of toxic reactions in this series is probably ascribed to the fact that the majority are ambulatory office type patients and are therefore treated on minimal doses. The fact that continuing benefits may still be produced on reduced dosage may prove that even smaller doses than those presently recommended may be equally therapeutic. With a few exceptions, most of these patients are taken off their medication on an average of six to eight weeks. Several chronic, recurring depressed patients are being studied on a maintenance program, and if toxic responses are to appear, they will undoubtedly do so in this study.

Toxicity undoubtedly decreases with experience with any drug. My own experience has been to become very familiar with the single compound type of drug which is available these days and to know it well in all of its benefits and in its adverse reactions, if any.

These compounds all have the advantage of being single compounds, and therefore, their usefulness can be much more readily appraised and their toxic reactions controlled, than if they were in a compound form.

In terms of rapidity of action and toxicity, I feel the drugs should be listed as follows: *Rapidity of Action*—Catron, Marplan, Nardil, Niamid, Tofranil; *Toxicity*—Marsilid, Catron, Marplan, Tofranil, Niamid, Nardil.

Medicine and Psychiatry in the U. S. S. R.

ARNOLD A. HUTSCHNECKER, M.D.

The discovery of the unconscious and its profound effects on the mental and physical functioning of man is perhaps the greatest contribution psychology has made to medicine in the first half of this century. Indeed, the majority of researchers in the United States and other countries of the Western World consider the vast quantity of mental life, which at one time had been conscious and then became repressed or which never has reached consciousness, to have a more powerful effect on the psychodynamic functioning than the conscious mind.

Soviet medicine rejects the concept of the unconscious as it does Freudianism or any related school of psychoanalytic thought. During August 1959, members of the U.S. Committee of the World Medical Association undertook an inspection tour through the Soviet Union and Czechoslovakia. In Kiev, the first stop, I raised the question about psychotherapy at the Neurological Clinic of the "October Ninth Hospital." The thousand-bed mental hospital, called the Pavlov Institute, could not be visited at that time because of repairs. It was difficult to obtain a clear picture of what was being called psychotherapy, as is indicated by the following question and answer period:

Q.: "Do you use psychotherapy?"
A.: "We talk to the patients when necessary."
Q.: "For how long?"
A.: "That depends."
Q.: "Do you talk for an hour?"
A.: "Not that long."
Q.: "For ten minutes?"
A.: "Longer than that if necessary."

A much firmer rejection of the psychodynamic point of view came in Leningrad. Professor Timofev, who is the Vice Director of the Bechterev Hospital, as well as Chief Psychiatrist of the Soviet Army and Chairman of the Commitment Commission, stated categorically that psychoanalysis was not practiced there, because, as he put it, "I am not sure that Freud was correct." Lobotomy and insulin shock therapy also were not practiced at his hospital. Electric shock therapy was used less frequently now in favor of tranquilizers and sleep therapy.

The theoretical basis of Russian psychiatry as well as the treatment for mental, nervous, and many physical disorders such as essential hypertension, is based on Pavlov's work at Koltushi, a small village of scientists, about 20 miles north of Leningrad. There, Pavlov had studied different types of behavior and features of inheritance. During the war the Germans occupied Koltushi and killed all animals, among them many generations of conditioned dogs used for the study of genetics. Now, new generations of conditioned dogs are being bred in order to resume the study of behavior and genetics. Four of our group were privileged to visit several laboratories at Koltushi where we could see not only various types of decorticated dogs, but also an immense program of reconstruction.

The Pavlov Institute consists of a theoretical division in Leningrad and the experimental institute with about twenty laboratories in Koltushi. One of the laboratories dealing with oncology studied the different development of malignant tumors in rabbits with different types of nervous systems. Professor V. Fedorov pointed out that the cause of artificially produced malignant tumors was found to be the same in most animals with an identical course of conditioned activity. Malignant growth developed rapidly and soon resulted in the death of rabbits of "equilibrated, mobile nervous processes" and in

a group classified as "inhibitory animals." A slow and prolonged course of the disease was observed in "excitable, inert animals." To my question as to whether "depressed and hopeless" animals were more prone to cancer or showed a greater progress of the disease, Professor Fedorov answered with an emphatic affirmative.

Pavlov, after he had established differences of behavior due to environmental factors, turned in 1930 to psychiatry, publishing a paper called "Trial Excursion of a Physiologist in the Field of Psychiatry." (From *Archives Internationales de Pharmodynamie et de Therapie,* 1930. In the volume dedicated to Gley and Heymans.) He demonstrated experimentally that the human organism as a whole as well as all its parts has tiny areas of representation in the cortex of the cerebral hemispheres. The higher functions, such as speech and thought and which exist only in man, Pavlov called the *Second Signaling System.* He explained the conditional reflex as an arc or a sort of short circuit in the cortex, between the afferent centers and the tiny visceral representations in this multi-billion mosaic structure of the brain.

The dynamic system of the cerebral cortex operates through a continuous interaction of excitation and inhibition. Psychic troubles are believed to result from a clashing of the forces of excitation and inhibition and the strength of such a collision. Pavlov and his school observed that when an overstimulation was strong enough to threaten the life of the cells, inhibitory processes of their function would take place in order to protect them from exhaustion or destruction. This reaction, called "protective inhibition," plays a most important role in Russian psychiatry, and forms the basis for the treatments of nervous, mental and many physical diseases. Included in this therapy is a training of the inhibitions, psycho- and lately hypnotherapy, drugs, physiotherapy, medical physical culture, and protracted sleep. This latter therapy is induced by a machine and consists of a pair of electrodes placed over the eyes and the occipital area of the skull, through which a current of 127 volts and 10-25 milliamperes were given in 10-100 impulses per minute.

Among the methods of rehabilitation of patients, occupational therapy plays a main part. At Bechterev Hospital in Leningrad, we were greatly impressed by watching patients being trained in a variety of occupations. According to Pavlovian principles the tasks of the patients are selected according to how ill they are; the sicker the patient, the simpler the task. As a patient improves, more complicated tasks are given to him until he completes a finished product, symbolic of a process of integration as, for instance, a fountain pen, which was given to us as a present. The working rooms at the Bechterev Mental Hospital looked very much like a small factory producing pajamas, underwear, belts, shoes, hammocks, TV antennas and other items. There were tool-making shops, metal and wood shops. All the manufactured goods are useful products and the emphasis is on helping the patients to return to a normal life. Schizophrenics worked together with epileptics and other neurological cases. Significantly, the patients, although ill, are being paid full salaries with pension rights. This, it is believed, will restore a patient's self-respect, his sense of reality and usefulness.

The acute ward had glass windows without iron bars. The open side of this stairway was protected by ropes and hanging nets.

During the question and answer period we learned from Professor Timofev, among other pertinent facts, that homosexuality is considered a crime in the Soviet Union and is therefore punished. He had seen only very few cases treated in "various ways," including insulin shock, but with no results. We were told that due to the system of socialized medicine

there was practically no narcotic-addiction in the U.S.S.R. except for some cases in Central Asia. There was no literature about it.

Medical and psychiatric care in the Soviet Union is adequate and functions well. Most hospitals are old in structure and some of the equipment is antiquated by American standards; other equipment, such as electroencephalographs, was modern. All the hospitals and wards we visited were immaculately clean, and almost all corridors had arrays of green plants. Most of the hospitals we visited had suffered heavily during the war and are being rebuilt and modernized.

The most amazing experience to this observer lay outside the medical and psychiatric field, however, and in what seems the most gigantic experiment ever conducted in the history of man, namely, a mass application of the Pavlovian principle by a government to reshape the behavior of all its citizens. The very method Pavlov had used to produce an ideal type of a "strong, balanced, alert" dog is applied to condition the vast population of the U.S.S.R. in order to achieve Pavlov's hope: ". . . the perfection of the human race of the future."

Whether this experiment will prove successful is perhaps for another generation to determine. As scientists we must not concern ourselves with political doctrines but retain an open mind and examine, without passion, the views and methods of others. As physicians we can have but one common enemy and that is the suffering of man and his diseases—be they of body or mind—and, in this battle, we cannot afford to disregard ideas and discoveries because of political boundaries. The cordial reception our Soviet colleagues extended to us and their full cooperation in allowing us to examine facilities which had been closed for so many years were hopeful signs of a closer and more fruitful exchange of concepts toward our one mutual goal, a peaceful, healthier and saner society of man.

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In spite of the fact that its methods have long since been reduced to principle, it is amazing to find scientific psychotherapy so little utilized in the treatment of old age and chronic invalidism. This is all the more shocking when one considers the not inconsiderable success obtained without and within the profession by individuals who realize the value of optimism and healthful suggestion, even though they know practically nothing about the scientific application of even these psychotherapeutic measures.

Quoted by *I. Goldfarb, M.D.*
American Handbook of Psychiatry I.

The Psychosomatic Moment in Therapy

ARTHUR N. FOXE, M.D.

The original title of this paper was: "Psychological Aspects of Drug Use." It soon became explicit as "A Psychologic Aspect of Drug Use." Then it was more specifically and correctly called "The Psychosomatic Moment in Therapy." The paper divides itself into three parts. The first examines the concept of relation as a loose and inadequate term. The second examines an example of therapy and the third isolates the Psychosomatic Moment and gives examples of how its content may be handled.

The physician uses drugs when he prescribes them for a sick person. The physician, therefore, is the *agent* in the use of drugs. Drugs are used by the sick person when the prescription has been filled and he takes the amount prescribed. The physician is the agent whereas the sick person is the *patient*. There are many psychologic aspects in the roles of agent and patient, but also in the mysterious realm that lies between them. The technical and lay publications, in one way or another, comment considerably on the patient's use of medicines. There are occasional esoteric papers, one may suppose, on the psychology of the physician when he prescribes some drug.

It is common to speak of the relation existing between physician and patient, but the word *relation* is hardly adequate in describing the realm wherein an exchange of some sort is made between physician and patient in drug prescription and use. The word relation may seem to have a sort of objectivity. But as fashionable as it may be in the physical sciences where it is used in connection with certain phenomena, it has only a specious objectivity in psychology, and omits vast streams and drifts of psychologic content. The word relation, in science, implies a sort of connectedness. This connectedness is truly no valid baggage, or at most a partial and occasional baggage on the psychological voyage between the physician and the patient. What happens between doctor and patient is not exactly something moved, something given, something made, as the words relation, datum, or factor imply.

To bring our subject to a more specific level we may examine a real situation. The real situation, let us say, is when the physician, confronted with a patient who complains of insomnia, prescribes a hypnotic—one of the many capsules or pills that are available and are so valuable in medical therapy. The first night the patient sleeps. The second night he sleeps less. And the third night he sleeps not at all. The physician may increase the dose, change the hypnotic, hospitalize the patient, or do one of a number of other things. Let us assume, for the sake of argument, that the patient has no obvious disease such as brain tumor or any other disease readily detectable in a hospital, given time and study. What has happened? Why does the hypnotic fail to work? One might say the body developed a tolerance for or resisted the drug, or rejected it because of its noxious qualities. In other words, the body refuses to use it. Then does the body believe the insomnia to be the lesser of the two evils? One may adduce many physiological reasons as to why such things occur.

But, certainly, a physician with a psychological bent may inquire into other aspects of drug use. One of these is the *aura* about the physician. The adult, who owes the careful if not actual moment of his birth to the physician, who owes his successful navigation through the diseases of childhood to the physician, and who later owes the protection and rescue from injuries and illnesses to the physician, un-

wittingly and not improperly, endows the physician with a certain aura. Today, physicians may be a little more materialistic, but the aura still exists and has added to it the massive publicity that accompanies much drug selling. Incidentally, today, when so many children already have been reared on psychiatry, the psychiatrist is having some of this aura, rather than superstition and fear, placed about him. The physician's prescription blank, its little symbol of medicine, the strange latin and chemical terms, the instructions, the precise little phial or pillbox—these are all little spells, little charms, little *incantata vincula,* so to speak. To these may be added the few words of instruction dropped between agent and patient or pharmacist and patient. These words are the psychological lycopodium that coats the pill. The bits of feeling, consideration, and all the manifestations of the head, heart, and *persona* all fall into this little mixture called a pill. The elements are numerous and subtle. And so each pill is a miniscule discharge of a miniscule gun in the doctor's armamentarium. Thus one may see how difficult it is not to give a shotgun prescription. Patients do notice these subtleties. Recently one patient wondered how a tiny Bonamine tablet could help when a larger Serpasil, and an even larger Thorazine tablet had failed.

It is time to return to our patient who is suffering with insomnia and who may be resentful of our neglect of him. The pill he received, the aura and all the little spells and incantations that have been mentioned, represent indeed a small experiment or a small therapy in magic. This aids as well as is aided by the chemical effect of the drug. The physician is the *magus* and he prescribes with the authority of majesty. Although the latin origins of these two words is not the same on surface examination, they do connect. The more distressed the patient is, the more he will expect magic and the rapid and efficient dispersal of his symptoms. But dispersal of the symptom with a magical element, even though it bear the King's touch of a pill, does not always come to pass, nor is this the only way of handling the patient's complaint which is tossed on the proscenium before the physician. The psychoanalyst, for example, is less concerned with a magical result. He *patiently* listens to the narration of the symptom and lets the patient become the agent. He surrounds the symptom with an affective or emotional quality or history. He uses it as a stepping stone to the past. In a sense, an analysis may become an endless quest by the patient for a magical solution as the distress or anxiety flows to each fragment of his past history. The analytic approach is rational as well, but it, too, is not sufficiently often effective.

There is a method which does not deal with magic or reasoning into the unconscious. When the patient complains of insomnia, the physician does not have to utilize magic or rationalization into the unconscious. Firstly, he may be aware of an elementary principle. Many patients, if not most, are reluctant to go to a physician until their symptoms are very distressing. Even then they are reluctant to have a complete examination. To begin with, they extend or reveal only the diseased part or the most distressing symptom. A self-preservative principle makes them cautious. The practical and wise physician senses this and may make an initial attempt to solve the problem with the little pill and the little magic, *la petite magie.* When the symptom persists, he makes a more thorough clinical study. If he is not hasty to relieve the symptom with his medicine and makes proper inquiries or sometimes merely waits a bit, the patient may reveal altogether conscious dreads and anxieties that he previously dreaded revealing; that he might die, might become insane, or that he has some dread disease. Here is the

point at which a condition may become almost purely somatic or psychologic, depending on the physician's approach. Here is the psychologic or somatic moment of decision; what may be called the "Psychosomatic Moment in Therapy."

An examination of all the ramifications leading from this point would take us into the vast area of a correct therapy that is beyond this presentation. A peephole view of perhaps the most dramatic although usually ignored moment in medical therapy has been presented. For the most part this moment is generally handled intuitively or not at all. This is a rather crude state of affairs. Perhaps two criticisms of this presentation could be made. One is that it is just common sense. If this were the case, the presentation would be the first examination of a momentous moment in the realm of medical common sense. Another possible criticism is that it is naive. Considering the massive amount of verbiage that masks as psychology today, the criticism of being naive might be gratifying. Then, too, the psychology of *naiveté* itself is an unexplored field.

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One of the most valuable aspects of the tranquilizing agents—and perhaps the secret of their success in mental illness—is the hope they have instilled for patient recovery in both physicians and patients. The patients have received more personal attention and psychiatry has been helped to return to medicine.

E. J. Moore, M.D.
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Psychotherapy is the optimum utilization of every ethical means at the physician's command to help the patient understand that his previously neurotic patterns of behavior, although perhaps once suitable, are no longer either necessary or advantageous, while at the same time helping him to realize by subjective analysis, personal example and progressive experience that more comprehensively adaptive and creative ways will also be found to be on the whole more pleasurable and profitable.

Archives of General Psychiatry, Sept. 1960.
Jules Masserman, M.D.

The Effect of Phenelzine in Psychosomatic and Psychophysiologic Illnesses

(A Final Report)

WALTER L. EVANS, M.D.

In a preliminary report[1] it was hypothesized that phenelzine* benefits patients with psychosomatic disorders by allowing them to direct normal "positive-aggressive energy" outwardly toward environmental challenges instead of inwardly into somatic channels. It was further suggested that this effect may result from the drug's inhibitory effect on enzymes that destroy serotonin, norepinephrine, and other biologic amines which give rise to an optimistic affect and effective positive action. The early report was based on results obtained in a limited series of patients, chiefly with musculo-skeletal disorders. The evaluation has been continued in patients with disorders involving other organ systems in an effort to corroborate the original hypotheses. The following is a report of the additional findings and a restatement of the previous premises regarding the drug's possible mode(s) of action.

MATERIAL AND METHODS

The 161 patients (105 women and 56 men) selected for treatment were seen in private practice during the past year. The patients ranged in age from 21 to 68 years. In addition to various organic disorders (Table I), all the patients exhibited a symptom complex indicative of depressive affect. This was characterized by varying degrees of indifference, physical inactivity, reduced intellectual interests (inability to concentrate, indecision, impaired memory, etc.) pessimism, anxiety, lassitude, sleep disturbances, constipation, impotence, amenorrhea, feelings of unreality, anorexia, or bulimia, and weight loss or sudden weight gain. All these symptoms were not present in each patient, of course, but were found in various combinations, often accompanied by some atypical somatic symptoms such as "tightness" in the head or vague abdominal discomfort. All the patients had been completely or partially refractory to treatment with drugs of proven pharmacologic activity that were prescribed as indicated by their presenting organic symptoms, and to treatment with a variety of tranquilizing and central stimulating drugs.

As in the previous evaluation, an effort was made to avoid "conditioning" the patients to any therapeutic influence by initiating therapy with no more conscious enthusiasm than was done with previous medications. In order to limit physician-patient contact, psychotherapy was employed only when a severe acute personal crisis arose. Before initiating therapy with phenelzine, all the patients were interviewed to determine, among other things, whether they possessed mentation indicative (or suggestive) of suicidal tendencies. Rather direct questions were, if indicated, asked during this part of the interview, since the drive to commit suicide is either compelling or non-existent and cannot be "planted" by someone else. All the interviews proved negative in this respect. During the first two weeks of treatment patients were instructed to take one 15 mg. tablet of phenelzine three times a day. At the end of this period the patients were interviewed and examined and, depending upon their improvement or the appearance of side effects, they were maintained on the same daily dosage or in-

*Supplied as Nardil, T.M. of Warner-Chilcott Laboratories, Morris Plains, New Jersey.

structed to take one 15 mg. tablet twice daily. If they evinced a satisfactory improvement after two additional weeks of treatment, the daily dosage was either maintained or further reduced to one tablet a day. At this point in treatment, patients were maintained on the current daily dosage for the remainder of the evaluation. Duration of treatment averaged 16 weeks. Thymol turbidity and cephalin flocculation tests were done before and after one month's treatment in a limited number of patients as a "spot-check" for possible untoward effects on liver function.

Sixty-five of the 161 patients received ancillary medication as follows: 46 patients with either rheumatoid arthritis, fibrositis, chronic "low-back" pain, herniated disc syndrome or neuralgia received 10 grains of aspirin four times a day; five of the patents with rheumatoid arthritis were also taking prednisone in total daily doses ranging from 5.0 to 10.0 mg.; 11 patients with radiographically proven duodenal ulcer took 90 cc. of milk once between each meal and before retiring (their diets were not otherwise altered); 8 patients with angina pectoris took 1/100 gr. of nitroglycerin, as needed. Response to treatment was judged as: 1) Marked—complete or nearly complete relief of depressive and organic symptomatology; 2) Moderate—partial relief of depressive and organic symptomatology; 3) Minimal or none—slight or no relief of depressive and organic symptomatology.

TABLE I

Response to Phenelzine According to Diagnosis

Diagnosis	Number Treated	Improvement: Marked	Moderate	Minimal or None
Functional Gastrointestinal Disorders	13	11	1	1
Duodenal Ulcer	11	8	1	2
Glossodynia	1	0	1	0
Dumping Syndrome	1	0	1	0
Rheumatoid Arthritis	10	2	8	0
Chronic "Low Back Strain"	14	9	3	2
Herniated Disc Syndrome	8	5	1	2
Neuralgia of Chest Wall	7	2	3	2
Fibrositis	7	6	1	0
Arthralgia	3	2	1	0
Bursitis	2	1	1	0
Tendonitis	1	0	0	1
Hypertension	26	13	7	6
Angina Pectoris	23	12	5	6
Vascular and/or Migraine Headache	6	4	2	0
Raynaud's Disease	1	0	1	0
Bronchial Asthma	4	1	2	1
Chronic Bronchitis	9	0	7	2
Chronic Atopic Dermatitis	4	1	1	2
Chronic Urticaria	3	3	0	0
Reactive Depression	3	3	0	0
Psychoneurosis with Severe Anxiety	3	0	0	3
Hepatic Cirrhosis	1	1	0	0
TOTALS	161	84 (52%)	47 (29%)	30 (19%)

GENERAL RESULTS

General—Over-all results are shown in Table I and are consistent with those reported previously. As will be noted, 81% of the patients responded satisfactorily to treatment with phenelzine; the remaining 19% obtained little or no benefit from the drug. In those who responded, the initial effect of the medication was usually evident within the first week or ten days of treatment, and was characterized by a decrease in the severity of depressive symptomatology. Most patients commented that they "felt better" at this time, while in others improvement, as reflected by increased communicativeness and/or a relaxed facial expression, was quite noticeable both to me and to members of the family with whom I had contact. Within two to three weeks of treatment, the intensity of depressive symptoms had become greatly decreased; in approximately one-third of the patients, these symptoms had disappeared altogether. At this point, because they were no longer "over-powered" by symptoms such as fatigue, sadness, and pessimism

and because they were usually eating and sleeping better, most of the patients were very enthusiastic about their improvement. Instead of reporting that they "felt less despondent," however, most patients reported their improvement in terms of "target" symptoms related to their psychosomatic disorder. For example, remarks such as, "I'm not having as much pain in my back as I used to," or, "that pain in my chest hasn't bothered me for over two weeks," were frequently encountered. As with any form of therapy, not all patients obtained the same degree of improvement after equivalent periods of therapy.

From an over-all analysis of the patients' individual response to treatment, it is felt that two general comments can be made regarding the therapeutic effect of phenelzine in patients with psychosomatic or psychophysiologic disorders. For the older patient in whom an "organic" disorder has persisted for several months or more, at least two weeks of treatment are required before significant improvement may be noted. During this period the physician should see the patient as frequently as possible and encourage the patient to continue with the medication. Allowing patients of this type to discontinue treatment prior to two weeks should not be permitted unless, of course, the patient complains of side reactions. The level of lasting improvement is usually somewhat more likely to be punctuated by temporary relapse in patients with prolonged illnesses than in patients whose symptoms have prevailed for shorter periods of time. A similar pattern of response is seen in patients who possess a significant degree of overt anxiety at the start of therapy, or who develop moderately severe manifestations of anxiety in the wake of decreased symptoms of depression. Perhaps, as has been shown by English[2] in his patients, the addition of a tranquilizing drug would have produced a more favorable response in patients of this type.

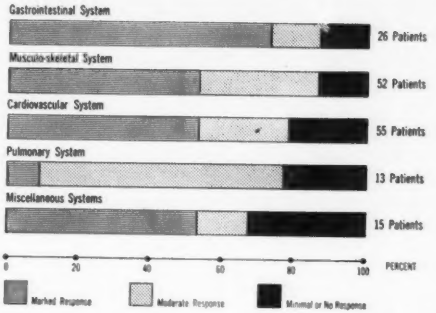

Figure 1. Response to Phenelzine According to Organ System.

SPECIFIC RESULTS

In Figure 1 results are grouped according to the organ system involved in the patient's somatic manifestation of the illness.

Gastrointestinal System

The most outstanding results (89% satisfactory response) were obtained by this group of patients, the majority of whom had a primary diagnosis of either functional gastrointestinal disorders (13 patients) or radiographically proven duodenal ulcer (11 patients). Following an average of three weeks' treatment with phenelzine, during which time an underlying depressive affect was normalized, patients in the former group frequently reported that intestinal "cramps" were no longer bothersome or that periods of alternating diarrhea and constipation were less frequent or non-existent. Following somewhat longer treatment (up to four weeks in some), patients with duodenal ulcer mentioned that gastric distress manifested as heartburn, indigestion, and typical epigastric pain was significantly decreased. Although several of the patients who initially complained of night awakening were sleeping the night through, it was impossible to determine whether this resulted from the drug's effect on the depressive component or from some indirect effect on the disease state. The better than average results obtained in this

group is hardly surprising, since it is generally felt that the gastrointestinal system is more easily affected by the psyche than any other organ system.

Musculo-Skeletal System

The results (88% satisfactory improvement) obtained in this group of patients closely approximate those in the former group and, to some extent, are no less surprising in view of the findings of Scherbel[3] and Bosworth, et al.[4] The distribution of marked and moderate responses, however, seems more indicative of the drug's general efficacy in depressed patients whose symptom complex involves "organic" disease. While improvement was seen in the majority of patients in each diagnostic category, the most outstanding responses were seen in those with rheumatoid arthritis and fibrositis. All the arthritic patients, in addition to exhibiting a more normal affect, experienced a diminution of joint swelling and increased joint movement. After four weeks of treatment with phenelzine and appropriate step-wise reduction, prednisone was discontinued in four of the five patients who had been receiving up to 10 mg. of this drug daily. In one patient, however, the daily dose of prednisone could not be reduced.

Cardio-vascular System

The results (80% satisfactory improvement) obtained by this group of patients are not significantly different from those obtained by the former two. Results in the patients with angina pectoris were characterized by a decrease in the intensity and frequency of anginal attacks. In 12 patients (56%) these symptoms were no longer present when phenelzine had been discontinued following 3 to 4 months of treatment. The results observed in these patients approximate those reported by Hobbs,[5] and are somewhat better than those of Russek,[6] but are less favorable than those cited by Winsor[7] and Ende.[8] It is, of course, difficult to account for the divergence of these results; however, one explanation may lie in the type of patient being treated. For example, it appeared that patients in whom depressive symptoms were most prominent tended to respond better to phenelzine than those in whom "organic" symptoms were most prevalent. Five of the six patients who failed to benefit from the drug were of the latter type. The therapeutic significance of the effect of phenelzine in angina pectoris, however, is not fully understood, particularly since no evidence of improved cardiac function could be detected in the post-treatment ECG tracings of patients no longer complaining of pain. It has often been suggested that patients who are freed of their anginal pain by this or similar drugs, should be cautioned about excess activity. While cautions of this sort are necessary for patients with moderate to severe cardiac damage, they should be avoided or de-emphasized whenever possible in order to promote normal activity and productivity and preclude the patient making himself a psychic "invalid."

The degree of response in patients with hypertension was essentially similar to that of patients with angina. The effect of phenelzine on systolic and diastolic blood pressure is shown in Figure 2. Following a duration of treatment averaging three weeks, decreases in systolic and diastolic blood pressures averaged 47 mm. Hg. and 20 mm. Hg., respectively. The blood pressure of 13 (50%) patients was within normotensive levels (140/90) when treatment was discontinued. Twelve of these patients are still taking 15 mg. of phenelzine daily and are now maintaining the same reduction in pressure after 3 to 9 months, without encountering collateral drug effects.

Pulmonary System

While the over-all results (77% significant improvement) are essentially equiva-

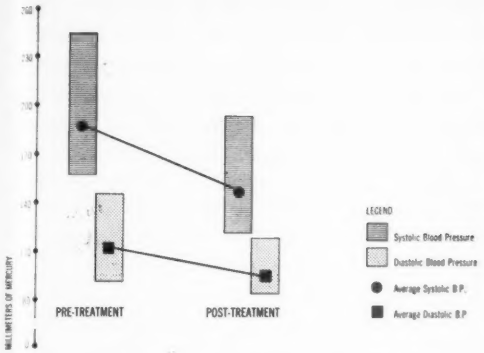

Figure 2. Effect of Phenelzine on Blood Pressure.

lent to those observed in previous groups, the percentage of patients who obtained a marked response is significantly lower than average. This latter result seems related to two factors. The first and probably the most significant one is the small number (13) of patients included in the series. However, as mentioned in a previous section, an additional factor in several patients involved a very latent depressive affect and often advanced pathology. As will be noted from Table I, the patients with bronchial asthma obtained better results than those with chronic bronchitis. Without exception, the degree of pathology existing in the latter patients was far more prominent than the symptoms of depression.

Miscellaneous Systems

The heterogeneity of organ systems involved in the primary diagnosis of patients in this group precludes making tangible generalizations regarding the drug's specific effect in any one disorder. This factor, together with the small number of patients in each diagnostic category, undoubtedly accounts for the below average response of the group to therapy. If these factors are disregarded, it would appear that phenelzine is moderately effective in patients whose depressive symptoms accompany chronic disorders such as cirrhosis of the liver, urticaria, and atopic dermatitis. Phenelzine also appears effective in patients with reactive depression who do not possess somatic depressive equivalents, although only three such patients were treated. However, based on the rather discouraging results shown by the psychoneurotic patients whose symptoms were predominantly related to a marked anxiety, it would appear that patients of this type are not often suitable candidates for treatment with phenelzine. As mentioned previously, concomitant treatment with tranquilizing drugs may be of value in these patients, but no attempts were made to combine these drugs in this group.

SIDE EFFECTS

No serious side effects were observed in any of the 161 patients included in the evaluation. Three women, all of whom were in their sixties, developed edema about the ankle during the first four weeks of treatment. The edema disappeared when the dose was reduced by one-third or two-thirds for 14 days, and did not return when it was increased to the level at which this effect was first observed. Repeated examinations of all patients failed to reveal hepatic tenderness of hepatomegaly. Even the patient with cirrhosis of the liver who received phenelzine for 21 weeks failed to develop changes in the hepatogram. Except in the patient with hepatic cirrhosis, liver "function" tests were always within normal limits. Measurement of blood pressure failed to show any consistent postural changes; deep tendon reflexes were not perceptibly altered.

COMMENT

Because of the multiple guises which it can assume, depression is often overlooked (or consciously ignored) in favor of a strictly organic diagnosis. Misdiagnoses can usually be avoided, however, by taking sufficient time during the pretreatment interview to determine exactly why

the patient decided to seek medical help at this particular time (i.e., to elucidate precipitating factors) and to obtain as much information as possible concerning the patient's past and present behavior. Whenever convenient, verifying this latter information "diplomatically" with relatives or friends can be helpful since, by and large, depressed patients tend to deny psychogenic symptoms because they equate them with personality "weaknessess" or interpret them in terms of the taboos which society has placed on mental illness. When the facts are assembled and analyzed in a manner which permits a viewing of the patient in a perspective encompassing his psychic, somatic, and sociologic environment, the presence of the depressive syndrome, with or without elements of anxiety, generally becomes blatantly obvious. Although there are a great number of patients who will not tolerate even a tangential exploration of emotional content, the constellation of physical symptoms listed above, alone, is quite enough to establish a presumptive diagnosis. Even though all factors may point to a diagnosis of depression or the anxiety-depressive syndrome, the possibility of a deep-seated organic disease can not, of course, be completely excluded. Absolute exclusion of organic disease is often impossible, however, and a compulsive, perfectionistic demand for "absolute certainty" can only lead to expensive laboratory and/or radiologic studies which prolong matters and increase suicidal risks. As soon as a diagnosis of depression is suspected, antidepressant therapy should be initiated, while a realistic utilization of additional diagnostic procedures is carried out. Informing the patient of the diagnosis is a delicate matter and one that must be assessed in terms of the patient's personality structure.

The psychodynamics of the depressive syndrome were presented in an earlier report, but will be reviewed here briefly as a means of explaining the effects produced by phenelzine. The ultimate source of "psychic energy" (Figure 3) involves basic drives, such as love, sex, etc., which are integrated by the ego into useful energy. The outward flow of "aggressive energy" is most frequently "blocked" by anxiety which usually arises in one of three ways: 1) from an unresolved (or unresolvable) conflict with reality; 2) from an immature or overly severe conscience (super-ego); 3) from a weakened ego that cannot fully integrate basic drives. If the cause of the anxiety-producing block is not removed or overcome, the aggressive energy is turned inwardly against the ego, resulting in an activation of depressive symptomatology (with or without symptoms of anxiety) and/or a psychosomatic disorder, provided a "channel" for this type of clinical manifestation is accessible. The mechanism involved in this latter reaction is presently unknown, although some investigators feel that it may depend on a powerful neural discharge over an autonomic outflow and a "susceptible" target organ.

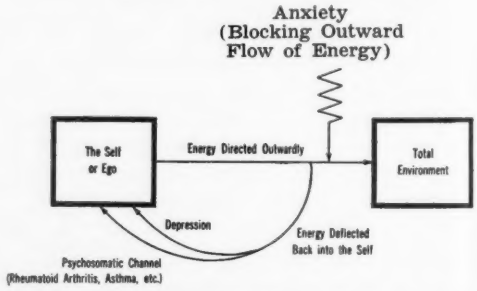

Figure 3. Schematic Representation of Relationships Between Anxiety, Depression, and Psychosomatic Disorders.

Since either depressive or psychosomatic symptoms can result from an ego-assault by aggressive energy which weakens the ego and immobilizes the patient, it would appear that both occupy the same psychodynamic position. The pharmacologic effect of phenelzine appears to reinforce the ego structure of such patients, thereby permitting aggressive energy to bypass the anxiety-block and to be di-

rected outwardly. Symptomatically, the patient becomes less depressed, complains less about "organic" disturbances, and becomes more active, both physically and mentally. In view of the fairly uniform response of patients in the present series, regardless of their somatic symptoms, and the effect phenelzine is reported to have on the cellular chemistry of the brain, it is not unreasonable to assume that a biochemical mechanism may be involved. The work of Scherbel[9] and others supports this hypothesis, since they believe that neurohumoral dysfunction is part of the etiology of many organic disorders. Further theorization regarding the mechanism of depression is not justified, however, in view of the limited knowledge now available. These are interesting concepts, indeed, even though their validity requires further study at a basic science and clinical level.

Perhaps the most outstanding result to be derived from this experience with phenelzine is the fairly consistent and often dramatic effect it has on patients, regardless of their somatic manifestations. Of equal importance, is the fact that this consistency of response was obtained in patients, all of whom had been refractory to previous treatment with tranquilizers and stimulants, and drugs of proven value in each specific disorder. Based on this experience over the past year, phenelzine seems to be the most effctive and safest of all the monoamine oxidase inhibitors employed by the author in treating patients with depression and psychosomatic or psychophysiologic disorders. However, it should not be inferred from this study that psycho-pharmacotherapeutic agents are the sole answer to the rather difficult therapeutic problem posed by many patients of this type. It is unquestionable that phenelzine constitutes a very promising approach to the situation, but it is not at present ready to challenge the position of psychotherapy or good "physician-patient rapport." When used concomitantly, superficial psychotherapy, phenelzine, a tranquilizer when needed, and any necessary treatment directed at the "target" organ involved, provide the most comprehensive and promising treatment of the depressive syndrome as described in this report.

SUMMARY

1. The use of phenelzine in 161 patients with psychosomatic or psychophysiologic disorders and a latent or overt depressive affect produced results (81% marked or moderate improvement) that were consistent with our findings presented in an earlier report.

2. A diagnostic approach is proposed for the detection of frequently overlooked depressive elements, which may be present with or without anxiety. It is further suggested that the incidence of depressive affect in combination with psychosomatic disorders is much higher than that usually reported.

3. The psychodynamics of depression and the effect of phenelzine on these mechanisms is presented.

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Hysterical Crises and the Question of the Hysterical Character

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Throughout the ages, the hysteric has received everything, from veneration and worship to mutilation and flagellation. The hysteric has been adored, revered and feared, despised, exorcised, castigated and psychoanalysed. Such an array of rational and irrational reactions which the hysteric can evoke in others leaves little doubt that by whatever name the disorder is called, it proved to be of social impact by way of its manifestations as well as by the responses of the surrounding society. One may even ask whether any given period selects its favorite hysterics or—and recent history is disquieting, indeed—might the hysteric have succeeded in creating his own epochal surroundings.

Whatever the case may be, the hysteric's contemporaries never ceased to wonder about people who seemingly live from crisis to crisis, who continually involve others and yet remain strangely non-involved during the crisis, or at least as soon as the crisis has run its course.

Thus, the 48-year-old, mildly graying wife of an academician decided to dye her hair for the first time in her life. She returned late for supper, berated children, maid and mate for their unpreparedness, then sank into a semi-comatose state on the adjacent couch, whispering that the hair dye might have been poisonous. She grew fainter and weaker by the minute, until the husband summoned an internist friend of his. This doctor arrived promptly on the scene and ascertained the physical intactness of his friend's spouse. Carelessly he said to her, "Dear, you're all right, even if I don't know much about the toxicity of hair dyes." After his departure the lady rallied, sat up, felt better and with a triumphant laugh remarked, "And *he* says he knows nothing about hair dyes! Look at his own hair. It never used to be reddish-brown before!"

This is just one of those minor, classical examples where everybody gets into the act, yet the hysteric who directs the show succeeds in remaining emotionally on the sidelines.

The Interpretation of the Hysterical Symptoms

In any event, the observers and participants have not only continued to wonder but have never ceased to interpret hysterical symptoms. Thus Hippocrates thought of some kind of uterine wanderlust with simultaneously escaping noxious vapors which in turn could enslave body and mind. Who could ignore the suggestion of a direct line that might have gone from there to smelling salts and perhaps even to some anterior round ligament suspensions? Although most everybody who attempted an interpretation began to suspect that a biosocially determined disorder might be to blame, one continued to treat the condition as the misbehavior of a single organ while the difficulty lay with the whole organism.[4]

As long as one attends to hysterical symptoms without due consideration of the hysterical character, the symptoms must remain inadequately understood. Hysterical behavior as such is rarely overlooked by layman or physician, yet once the symptoms are in evidence, professional scrutiny seems almost wholly focused on these. Of course, the physician has long been familiar with an impressive list of hysterical symptoms and their names, like globus hystericus, glove or stocking anesthesia, arc de cercle convul-

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Read before the symposium on "Crisis: The Recognition and Management of Emotional Responses to Critical Events" at the University of California School of Medicine, San Francisco, California, June 16-18, 1960, sponsored by the National Institute of Mental Health.

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sions, and so on. Yet, just when he is confronted with these symptoms, he usually—be it through educational tradition, or perhaps also in order to avoid the full emotional impact of the hysterical person—proceeds to arrive at a diagnosis by exclusion. Once he has ruled out structural lesions of disturbed physiological functions of an organ or organ systems under observation, he relegates the symptoms to an obscure state of mind and here the doctor-patient relationship may come to a premature termination.

Psychiatrists may not have been of too much assistance thus far. It certainly has not helped matters when in 1952, an outstanding and official committee on nomenclature of the American Psychiatric Association decided to abolish the term hysteria altogether and replaced it with the names of several defense mechanisms, derived from the study of the illness itself. Crises with hysterical symptomatology were now to be called "dissociative," "conversion," or "phobic" reactions, while the person who would react in this manner had to be categorized by diagnostic names like passive-aggressive personality or purely descriptive diagnostic terms. One may regard such caution a minor act of repressive ingratitude toward an illness to which psychiatry owes so much.[2]

Notwithstanding arguments about diagnostic labels or disrupting or disappointing doctor-patient relationships, the particular mode of behavior called hysteria continues to persist. It is generally acknowledged that the symptoms have undergone change. This could be compared to any language which adapts itself to the needs of the persons who use it for communication at any given time or in any given age. Whether the hysterical character in its most basic, dynamic components has undergone revision cannot be decided, unless one reviews both the interpretation of the symptoms and the conceptualizations and speculations about the hysterical personality. Perhaps the elaboration of some rather simple assumptions and general denominators will permit this time-honored companion of mankind not only to retain its rightful place on a patient's bedside, but may aid in more facile recognition, improved treatment and understanding of the hysterically endowed individual. This is not merely a matter of psychiatric theory, for unfortunately the hysteric has also on the somatic side of the ledger probably no greater claim to general health than other mortals. When he gets measles, mumps or a collagenous disorder, he may be his own worst enemy in obscuring a diagnosis. The misunderstandings to which the hysteric's behavior under stress may lead can frustrate and alienate most any doctor.

The Symptoms

If we once more remember that the symptoms of most illnesses have changed throughout the ages, the cardinal symptoms of hysteria are still considered to be:

1) *Inactivation* of organs or organ systems (for instance, paralysis)
2) *Increased functional autonomy* of organs or organ systems (for instance, cramps, tics, seizures)
3) *Increased autonomy of the mental functioning* (for instance, hysteric somnambulism and fugue, multiple personality, etc.)[4]

It is not only the difficulty in ruling out localized organ illness (cf. temporal lobe epilepsy), but the interpretation of the symptom in a psychological sense which leads to confusion.

Therefore the title "Hysterical Crises" constitutes not merely subservience to the over-all theme of the symposium; it is also not intended to introduce a new entity or syndrome. An attempt will be made to show that during the hysterical crisis or interaction, a good number of characteristics become visible which had before remained unrecognized or even unsuspected.

The Hysterical Crises

Some unfortunate regions happen to be the periodic victims of earthquakes. Once the catastrophe has occurred one clears the debris, rehabilitates the best one can, but few if any of the inhabitants become sufficiently frightened to leave the tainted region for good. However, an air of anxiety may persist for years to come. The case of the hysterical crises bears some resemblance. The crisis is usually first encountered at its peak during which the physician may gain sudden unexpected insights. He may see a whole chain of psychological connections and attempts by which the patient tries to cope with conflict and many times he does gain insight into a personality picture which he had previously not suspected. However, once the crisis has subsided, the patient may either negate the whole incident, he may never return, or in some other mysterious way succeed in making his surroundings forget that such an upheaval had ever taken place.

Thus, we may view hysterical crises as critical as well as typical human events during which the participants (and it may not only be the patient) aim to resolve conflict in a hysterical manner, by hysterical means, or if you care, with hysterical defense mechanisms. Such situations are continuously encountered in medical practice, yet will reach the psychiatrist's office only when the patient has finally agreed to get "sick on time."

Symptoms, Their Explanations and Concepts

In trying to explain hysteria in a given or individual case, one traditionally relies on longitudinal histories concerned with personality development and arrest, mental mechanisms like repression and subsequent reactions to impressive events. The physician who is consulted during an acute hysterical crisis finds himself in an infinitely less commodious position. The occasion is usually a momentous if not outright dramatic one. A night call, an urgent request for indispensable aid, an admonition to break the speed limit and to come right away. This already sets the stage for subsequent happenings, as any ambulance driver can attest, and to do justice to our favorite hysterics, it must be admitted that some hysterical ambulance drivers or even physicians may aid and abet the call for perpetual crises. Well, once having arrived at his destination, the physician may find himself at the bedside of a man with paroxysmal tachycardia just about to subside, while a perambulating spouse gives clues that the event was precipitated by some kind of sexual malfunction or an argument about the expected inheritance from a still rather lively and spry mother-in-law. Or the physician may be confronted with an equivocally acute case of appendicitis in a 17-year-old girl. All leads remain ambiguous and the doctor may wonder whether it is nobler in the mind to operate or to suffer the outrageous fortune of overlooked appendicitis at 12 o'clock midnight in a lonely country hospital with the only reliable laboratory technician away for an ill-timed honeymoon. This may not happen too often in our age of emergency prepared and equipped medical culture, but it is certainly remarkable how hysterical behavior of any kind leads *almost universally to involvement, to action taking, and to anxiety driven measures* of everybody who comes into contact with the patient.

Hysterical Symptoms During The Hysterical Crisis

After such anecdotal illustrations we may review the hysterical symptoms as they appear during the crisis. The general characteristics for the hysterical crisis may be described as: A) rapid in onset, B) impressive upon the surroundings, C) involving all possible participants, D) occurring in a peculiar state of mind. With regard to this state of mind,

most writers agree it exists and have their name for it. Freud called it hypnoid state; Janet remarked on the restriction of the field of consciousness; Charcot emphasized belle indifference and increased suggestibility,; and Purves-Stewart, with typical British understatement, merely noted increased emotionality in the presence of bodily discomfort.[11] It may already be stated here that these symptoms are not only highly impressive upon the observer, but tend to create in himself a similar state of mind, in other words, not only the patient remains overly suggestible. Yet, any such summary of the superficial symptoms cannot be too meaningful unless we connect the symptomatology with a certain personality picture, and thus aim at a conceptualization of the hysterical character.

Freud and His Interpretation Of Hysteria

Though many observers had suspected that the manifestations of a hysteric should have their antecedents in previous behavior or experiences, it remained for Freud to give meaning to hysterical symptomatology.[1] His initial observations on a number of patients with conversion symptoms and his previous experience with hypnotic recall of traumatic events enabled him to postulate a symbolic, emotional interpretation of the physically exhibited symptom. Initially he was taken somewhat aback by the degree to which some of his lady patients insisted that incest had been the favorite pastime of their fathers. Yet when he derived further clarification about the assumption of unconscious motives, half forgotten drives and quantitative as well as qualitative exchanges of emotional energy, his theory gained experiential ground and up to this time has remained the hitching post for theorists and practitioners in their attempt to explain hysterical behavior and characters. The word "hitching post" implies perhaps that some of the theorists may have used too short and too weak a halter rope to quiet their stallion. The libido theory and the oepidus complex have become cornerstones of analytical theory. Both have been shifted, re-arranged and re-conceptualized in the light of new clinical insights, but by and large —and in the case of hysteria more than in any other psychiatric illness—the hand remained fitted for the glove. Rivalry with the parent of the same sex, desire for the parent of the opposite sex and consequent ambivalent identification with both, were to take place in an atmosphere of tropical, affective heat in the absence of intellectual control or other forms of desirable air-conditioning. Thus, emotional growth was said to be arrested, delayed or continually impeded by the persistence of infantile motives. King Oedipus unconsciously propitiated toward his mother and equally unconsciously denied or even obliterated the memory of his father. Furthermore, emphasis on the genital level of libidinal arrest tried to explain the eroticizing or sexualizing quality of many of the hysteric's symptoms.

That this theory with all its implications of what is male or should be female is no longer sustained by even the most scrupulous of Freud's followers attests more to the vitality of Freud's intuitive insights than to the fruits of orthodoxy amongst some psychiatric fundamentalists. Titchener and Levine[13] in a recent book on "Surgery as a Human Experience" remark, "The near triteness of the oedipal concept of early psychological development reminds me that further clarification is needed here. The illuminations and rediscovery of a person's past does not mean that we come upon an 'Oedipus complex' and say 'Eureka.' The idea does not require ratification. Instead, in the individual's case we learn about the dynamic balance of a person's relation with his parents of each sex and how his particular and individual adaptation has been affected by these simultaneous relation-

ships." Maybe classical psychoanalytic theory can interpret the symptoms much better than the person, but we should be more than appreciative that psychoanalysis was able to propose the ego defensive character of the hysterical symptom. Later on, when the psychoanalytic movement proceeded from id and superego analysis to ego psychology (in other words from concern with the symptom and symptom defense to a question of how a personality could integrate conflictual desires and drives), little change occurred with regard to the understanding of hysteria. Judd Marmor[10] suggested an earlier fixation or libidinal arrest on the oral level. This contribution could have presaged concern with communication on the verbal and nonverbal level as orality in the psychoanalytic sense includes the evolving patterns of speech and subsequent symbolizations.

The Hysterical Symptom in Psychosomatic Interpretation

At this point, it also should be noted how psychosomatic concepts have changed their original basis of speculation. Modern psychosomatic research has become critical of repression and regression as it became obvious that one cannot translate without immunity from one semantic sphere or system into another. This did not discredit so much the symbolic interpretation and understanding of the hysterical symptom as it offended the increasingly more complex knowledge of physiological functions. First, a differentiation between hysterical and psychosomatic symptoms was elaborated. The psychosomatic symptom was said to be characterized by the presence of altered physiological function while the hysterical symptom seemed more a symbolic advertising picture than a physiological sequence. Moreover, in the hysterical symptom one would have to expect a symbolic correlation between the postulated traumatic event and the type of the symptom response. In other words, if oedipal crises were responsible for hysterical manifestations later on, current conflicts as they might occur in areas of sexual identity or behavior would have to provoke symptoms and these symptoms by their overt character, e.g., pelvic discomfort, frigidity, impotence, would in turn be reminiscent of the nature *of the conflict*. This view has undergone many changes since. Relevant in the context of this presentation seems the probability that there are different degrees of latitude with which a person can react to stress or to an alteration of his equilibrium. For whatever the reason the hysteric seems to have increased control over organs and organ systems, sometimes to a degree which only an Indian fakir could accomplish.[11] Yet, in terms of useful biosocial interaction it remains doubtful whether the hysteric's seemingly increased command over his own organs constitutes true advantage or evolutional progression.

This may conclude a perhaps moderately biased and patently inadequate summarization of the historical concept that led psychoanalysis to interpret the symptoms and later on to arrive at a picture of a hysterical personality and a potentially hysterical character. On the other hand, such lengthy discussion remained unavoidable since even the most ardent anti-Freudians have never been able to desist from attacking Freud's postulates in just such a manner that his theory—be it perhaps by virtue of negative feedback—has invaded our whole life and culture to a far greater degree than medical education at large.

Conceptualization of the Hysterical Character

Chodoff and Lyons[5] have re-examined the relationship between classical hysterical symptomatology and the hysterical character. They found that many of their patients who had a peculiarly hysterical personality profile did indeed show symp-

toms like conversion and dissociation. Yet, when they examined the issue in the reverse order, namely by scrutinizing the personality development of those patients who were hospitalized for conversion symptoms, etc., this ratio of conversion symptoms to hysterical character picture did not prove to be true. Although their observations remained relatively small in numbers, their conclusions deserve future study. In the meantime while it seems impossible to forecast from personality profiles exactly who might develop conversion reactions, it may be stated that the symptoms continue to be some functional incapacity, inexplicable to the patient and unreasonable to the doctor. At the same time the psychologically oriented observer may see some purpose in the presence of an amazingly good attitude of mind (Janet's *La belle indifference*). This enhanced pronouncement and speculation about the unconscious connection between an ideational content and an affective dissociation from the time of Charcot to the present. The fact remained that in the hysteric, physical symptoms suggest symbolic thought processes of past and present experience, however, no proof or even hypothesis was offered that these symbolic representations on the somatic level *must* be defensive in character. In other words, and this seems to me an important clinical feature, the concept of symptom substitution, replacement and even the supposed tragedies of symptom obliteration by suggestive medical methods are unproven in fact on a therapeutic level. This naturally like in most instances in medicine excludes the observer's error.

Mastery and Control

There is perhaps another equally adequate and attractive way to conceptualize a character, his traits and manifestations. Instead of the concept of defense mechanisms or adjustive techniques we might try to define the means by which mastery and control are attained and preserved by any given individual and in any possible situation. Such a perspective does not only allow for an enumeration of the descriptive characteristics, it would neither have to omit or dismiss the content-oriented premises of psychoanalysis and would also give clues why this or that person elects these or those ways to mediate between himself and his surroundings. Grossly, these means to sustain or avoid relationships must be verbal as well as nonverbal in character. Closer attention to these communicative devices may not only make the patient's behavior plausible, but provide the basis or at least the conceptual framework for corrective action in the medical setting. For control and mastery are the elements of exchange, contract and competition between the physician and his patient. The hysterical crisis is no exception.

The hysterical character has been vicariously described and slandered. As most everyone knows, hysteria by name and hysteria by historical accident was ascribed to women. As a recent author caustically remarks, this might be another observational error. For while one attributed hysteria throughout the centuries—from witches to saints—to womanhood, the observers have largely remained men and perhaps only the conclusion of the century might finally even things out.[5] Descriptions of hysterical symptomatology in men as they are seen in industrial and government medicine suggest that they occur more frequently under the picture of compensation neurosis or other neurotic reactions following accidental trauma. This should suggest the need for a thorough reexamination of the sex incidence in hysteria in the light of changing social and cultural context.

It is therefore not the intent of this presentation to arbitrate between multiple bias nor would it be possible to do justice to history's ample description of

hysteria or hysterical character. At present, most writers seem in agreement about certain features that are encountered at one time or another in those people who lend themselves to the label of hysterical personalities. Many are able to produce at one time or another hysterical symptoms, and if life and its stresses are not continually mediated in this manner we should hardly speak of a hysterical character. We may also take exception with regard to certain so-called release mechanisms as they are sometimes seen in individuals with underlying psychosis or brain syndrome. On the other hand, one could ask whether hysterical symptoms might not indicate a connection with a hysterical pre-disposition or premorbid personality.[8]

The hysterical character is said to be conspicuous by lability of affect, eccentricity, vagueness, shallow affectivity, dramatic exaggeration and histrionic demeanor up to the extreme degree of pseudologia phantastica. This sounds as if the annotators who compiled these characteristics did not like the subjects of their observations too well. Even Eugene Bleuler[3] mentioned in his description of hysterics their egoism, lying and vanity. And another observer, Kohnstamm,[9] spoke about a lack of health conscience. There is no doubt that the casual observer must view the impressive manifestations of the hysterical personality with a certain amount of critical reserve. This has not changed in recent times and it is often extremely difficult to defend the hysteric's moral integrity against the type of symptoms he demonstrates. As he continues to show that there are more connections between mind and body than scientific method has taught us so far, we tend to vilify the hysteric by attributing ulterior motives or outright sinfulness to him. I am thinking here of the whole concept of secondary gain, its confusion with what is called malingering or simulation. Unfortunately, the hysteric and his symptoms in his obliging way threaten to prove their detractors right, if not outright omnipotent.

The Hysteric as an Over-Adapter

For reasons which are not too well understood, the hysteric seems to be a magnificent adapter as long as an affective bond continues between him and his correspondent. This means if a man likes horses, the woman longs for the saddle, provided love continues. If a hysterical patient likes his doctor, he will receive equally beneficial results from treatment with barbidonna, chloral hydrate, hypnosis, or psychotherapy. But beware of the holy bond of transference being broken or even temporarily interrupted. The woman will say, "Well, I always hated horses, anyway." Or the patient will shift to another physician. Why must this happen? It seems that in both examples, relationships have occurred in a setting of grossly misunderstood mutual needs. The woman who submitted to equestrianship really did not like horses, but had no way of verbally expressing her preference; hence, she went along for the ride. Once her horse lover's probably mostly nonverbal ardor had cooled off, she felt herself forced to forsake him. The matter is no different with the patient. Here questions of "How much do you care for me?" are being cloaked in medical language, medical behavior, medical interaction. It is known to every physician how he must substitute for the emotional needs of his patients. The patients, according to the varying types of emotional normalcy or pathology may expect a truly chromatic scale from their caretakers. Whether we are aware of it or not, this scale or at least most of the white keys seem nonverbal messages, in fact, organ-body or gesture language for which the physician is only intuitively prepared.

The Relationship of Style and Content in Communication

In the hysteric's case, it is worthwhile

to ask an additional question: Is there perhaps any gross discrepancy between the style and the content of his communication which tends to obscure the decodification of the message by the person for whom it is intended?[6] Ruesch[12] states that "the hysteric says one thing and means another." Finally, the traditional references to the hysteric's vague, indefinite and generalizing type of language should direct attention to the manner in which he intends to make himself understood to his surroundings.

Imperceptiveness

One could use Marlon Brando's quip about an actor who "is a fellow who if you ain't talking about him, ain't listening," as a starting point. Hysterics conceive of themselves in a peculiar form. They assess their own feelings by the way their respondents seem to react to them; they externalize their feelings, yet seem imperceptive to the feelings of others. A schizophrenic may pinch *himself* and ask another, "Does it hurt?" The hysteric pinches his partner and then may remark on the painlessness of his communicative endeavor. Furthermore, one notes that the hysteric can be an extremely poor appraiser of others' potential responses. This goes for a certain visiting evangelist in Ghana as much as for some other astute ambassadors. Reactions of others are perceived in a sense of wish fulfillment, but never in terms of the prospective respondent's needs, the respondent's desires or attempts to convey or receive a message. The respondent is continually bewildered by a somatized or in case of love, sexualized context in the face of a rather innocuous content. Many an example could be given. Suffice it to mention the promiscuous but frigid woman, the Don Giovanni type conqueror who remains afraid of marital ties, and the perennial shopper for medical cures with distrust for any and all of the official representatives of medicine.

Verbal Imprecision

When one presses hysterics for interpersonal evaluations, when one asks what kind of a person is your husband, your mother, your child, one is astonished by a particular disability of the patient to state just those characteristics which would make the other person meaningful to him. The hysteric may answer with "some kind of a man," "some sort of a woman"; rarely is the observing physician able to ascertain a concise picture of this person through his patient's eye or verbal description. In a previous publication, an attempt was made to ascribe this type of communication to the silent or quiet variety of the hysterical personality and to arrive at a continuum of hysterical over-demonstrativeness through somatic language and complaints to a verbal deficit which these people seem to have.[2]

This, then, may add to the typical picture of the over-demonstrative, over-dramatic or over-responsive hysteric another dimension: the silent, the understating communicator who is verbally incapable of expressing feelings. Maybe he has never learned or experienced the emanations of feelings in another human being. For practical purposes he remains imperceptive of others and unable to transmit his feelings in words.

Possible Causes for Imperceptiveness And Verbal Deficit

One might speculate in terms of input and output, to use a fashionable simile. A schizophrenic seems overcome by anxiety since he has too large an input window and has never learned how to contract or to shut it down. Hence he is flooded by messages, impressions and relationships beyond his capacity. Quite to the contrary, the hysteric has for reasons which psychodynamics may well explain, not only learned to close his shutter, to narrow it and to make it a selective receptor at an early age, but by doing so he also may have deprived himself of an inordi-

nate amount of input. This ultimately would result in a deficient state of information about himself and others. The hysteric's principal capacity seems over-identification which so often is mistaken for true empathy with others. But whenever we press for real values, feelings, comparisons, judgments, the hysteric renders us embarrassed by his naivity and his lack of fundamental experience or knowledge. Whether abrogation of conventional information has occurred for reasons of dynamically determined infantile anxiety, whether for causes of input impedence on a biological level, or because information—as in the case of some exceedingly primitive family constellations—just was not available, must be left to speculation as well as to individual proof. The point of argument remains that in hysteria, regression is as much a concept and a hypothesis as is the idea that you can't deal or mediate between yourself and others with what you have never learned to master.

Maybe organ language is a more ancient mode of conveying information than verbal abstraction. On the developmental scale, this is as difficult an idea to prove as it is fascinating to argue about. The hysterical person seems to be bound to psychobiological over-adaptation, to physical compliance and non-verbal over-control while being devoid of the means of symbolic representations, concept formations and verbal control. This places him into a continually precarious relationship with others on the basis of deficient communicative verbal devices.

Thus, in our age of college grades, semantics and Madison Avenue confusion about the meaning of words, the hysteric may be even more liable to become a casualty of well intentioned medical endeavor.

The Physician's Difficulty in Deciphering the Hysteric's Message

Ultimately the physician's difficulty with the hysteric must center around his patient's pseudo-adaptability in the face of deficient expressiveness.[7] The patient can adapt to the medical situation by symptom production or language, but fails on the level of abstraction and interpretation. Initially most hysterics, whether we see them in medical, gynecological or surgical offices, or whether they come to us for psychotherapy, seem good patients. We like the way in which they accommodate themselves to us. But the honeymoon is soon over, once one insists on precision, perceptiveness and participation on the strength of their own motivation or for their own sake. Dependency reactions are only too well known in medicine and the hysteric's dependency demands read: "cure me, help me, but do it on my own terms." This sounds like an infantile effort to control the medical as well as any other situation and no wonder that hysterics are often pictured as being domineering, controlling or the taking-over type of character.

Yet perhaps—knowing about the hysteric's imperceptiveness and his verbal communicative disability—we may interpret his demand also as a request that his particular type of language be understood. While the patient complains of chest pains, he may want to say to his doctor, "You don't really understand me; you don't care for me; why don't you get my symbols straight? Control me while I cannot control myself, and perhaps even help me to make my body subservient to me." A physician who immediately replies with "Get thee to an analyst, Ophelia," is perhaps not always fully accepting his patient's message.

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Frigidity—Some Fallacies, Facts and Fancies

When wives are too restrained or frigid,
That makes their men relax their rigid
Code of conduct, thus liberating
Those who miss mating from mismating.
They then uncover new attractions
Who prove their love by proper actions.
So, wives who find sex hard to bear,
Must "waste their fragrance on the desert air."
While men, who're easily misled or lured,
Still find their psychic impotence not cured.

These rifts that mar the married state,
Can't help but make me-prob-a-mate,
"Cherchez la femme" beside(s) "l'homme,"
Which may unearth a torrid "pomme-
de-terre" who's causing all the tension.
(A type wives scorn as "beneath menschen")
The choice of men who go to town
Is "gals" who let their standards down.
But if these men value their lives,
They leave Miltown to calm their wives.

Sex, which fulfills Nature's intention,
Is not Old Nick's or Freud's invention.
For woman needs her man's proximity,
Averse to vice, for equanimity,
And vice-versa; no drug's tranquillity
Can match a man with full virility,
While Miltown has but fleeting charms
Compared to woman's loving arms.
Tho drugs may help some spouse save face,
There are many things drugs can't replace.

Sam Silber
Brooklyn, N. Y.

Psychosomatic Illness — An Adlerian Orientation

ABRAHAM I. BEACHER, M.D.

Although the term "Psychosomatic Medicine" is fairly recent, physicians have always known that the psyche plays an important role in disease and can express itself through the body. Alfred Adler called it organ dialect.

According to Adler, each individual develops his own particular style of life; his own way of dealing with life's problems. This process begins at birth. An infant is born helpless. He is surrounded by adults whom he visualizes as giants. He depends upon them for his needs, indeed, for life itself. This total dependency forms the basis for feelings of inferiority. A struggle toward superiority results — a striving from a minus to a plus situation. This striving generates the dynamic force behind all human activity and provides movement: in the healthy, towards perfection and a totality of personality; in the sick, toward a distorted way of facing life. Further, all men are not created equal. Some are born with organ inferiorities which further develop their feelings of inadequacy. In an effort to overcome these organ inferiorities further dynamic forces develop. There may be a consequent over-compensatory striving for mastery over the environment, for self esteem and acceptance, for superiority and perfection. In this striving, man develops a goal of which he is mostly unaware and which constitutes the "not knowing" part of his conscious or his unconscious.

In this struggle over his environment certain character traits appear: ambition, envy, greed, hate, aggression, compassion, cheerfulness, seclusiveness, submissiveness, etc.

His secret goal in childhood, his movement toward this goal and the character traits he uses in this movement constitute his personality, or his style of life. It is set early in childhood. It constitutes a subjective view of his environment and depends no longer on objective reality. He now perceives his environment within the framework of his style of life. His perceptions are distorted to fit into this particular mold. Alfred Adler called this "biased apperception."

The individual's style of life produces a method of function, either adequate or inadequate. Adequately, it fits the needs of the situation and we have good health. Inadequately, self esteem and social feeling are diminished or lacking. The responses are now neurotic.

Alfred Adler further stated that each functional illness is teleologically oriented. It is directed towards an end or shaped by a purpose. The patient uses his symptoms or character traits as a means of ruling, avoiding, exploiting or overcoming his environment. In other words, the type of illness a patient "chooses" as a defense against the demands of life depends upon whether he is the ruling, exploiting, avoiding or overcoming type—it depends upon his style of life.

Psychosomatic medicine is chiefly concerned with that large group of patients who present themselves to physicians in order to seek relief from symptoms which are not based completely on organic illness. These patients do not have sufficient bodily disease, detectable by laboratory means or by physical examination, to account for all their symptoms. The physician rules out any organic illness and is left with the conclusion that the symptoms are functional or psychosomatic.

The patient may present himself with symptoms of heart fluttering or indigestion or migraine headaches. The physician, and rightfully so, must first suspect an organic condition to account for these symp-

toms. Should the examination prove to be negative, the patient may be referred to the laboratory for blood or roentgenographic studies. The latter examination may reveal minor arthritic changes in the spine or a spasm in the colon. The strict organicist may try to use these findings to explain a psychogenic backache or nagging stomach-ache. If the symptoms persist, the patient is referred to one or more specialists until finally, every body orifice has been invaded by stainless steel, and all the flora and fauna of the body have been checked, tagged, and found guiltless. The patient is then informed that the illness is psychosomatic because nothing has been discovered.

A physician, after completing this battery of tests and examinations should take the time to explain that nothing has been left undone and that the patient, beyond the shadow of a doubt, is well from an organic standpoint. If the patient is reassured, he may accept the fact that he is well and a cure, or at least an amelioration of symptoms will follow. The doctor can go further and spend several sessions with the patient. The nature of psychosomatic illness is explained to him and his immediate problems are explored. If this should prove fruitless and his symptoms persist, the possibility of more extensive psychotherapy should be discussed.

Let us assume the doctor is not psychiatrically oriented. The patient is told there is nothing wrong with him. The physician may even intimate that the patient only imagines the symptoms or may even be a bit of a malingerer and should stop wasting the doctor's time and his, the patient's, money. "Go home and forget all this nonsense." "Pull yourself together." From this point on, the condition can deteriorate while he shops around from one doctor to another until he finds one who puts a label on his "disease." This last doctor then becomes a pathogenic agent. The illness now becomes iatrogenic and is finally official. He continues to seek relief from his symptoms. Many of these patients, having failed to get help from medicine, take a series of mineral baths, lavages, gavages, or drainages; or a series of injections; or spinal adjustments. The unorthodox practitioner at least promises relief. He frequently gets results because the patient feels that he, at least, is taking his symptoms seriously and is trying to help him.

Psychosomatic patients fall with about equal incidence into three main groups: The first group consists of those whose symptoms are caused wholly by emotion. A second group has illness based upon emotional causes but with an organic substrate. A third group is considered organic in that symptoms are related to the autonomic nervous system. In this group we find ulcerative colitis, asthma, peptic ulcer and essential hypertension.

CASE HISTORIES

The following three cases will, I hope, be illustrative of each of the above groups and a particular style of life.

Case 1: Claire L., a 44-year-old female, has suffered from severe migraine headaches since the age of 22. These headaches have occurred as often as two or three times weekly and have lasted twelve to twenty-four hours. Some weeks she was never free of symptoms.

She was the third of five siblings. When she was fourteen years of age her mother died of cancer following a lingering illness. Claire's two older sisters finished their course in business school and obtained secretarial jobs. Claire quit school and became the "mother," a euphemism for housemaid. Her father was not a poor man and could have hired a domestic worker and allowed Claire to continue school. He was miserly, however, and a martinet. He demanded a scrupulously clean house and meals served on time. Claire produced both. She told me that in all her childhood she had never heard a word of love, kindness or praise from him. She described her father as one who was silent, strict, fearsome and took time out only to find fault. Her older sisters had little more to offer. Since they were bread-winners, they were excused after supper and Claire was left with the dishes. She was a latter day Cinderella.

At the age of 16, she developed a sudden abdominal pain. She was alone at the time and became quite frightened until a neighbor responded to her frantic tappings on the wall. The doctor diagnosed it as appendicitis and she was hospitalized. As Claire put it, "my father went wild." He demanded the best surgeon and consultant, no matter what the cost. "I guess he was afraid he would lose his housemaid." Following the operation, she had private nursing in the hospital. Then followed a wonderful time. Her father gave her a gold watch! (She once told me she never had a second portion of meat because of her father's stinginess.) She sat in the back yard and rested while her friends called and gave her gifts. She finally was sent to the country for two more weeks of convalescence. During all this time, her two older sisters took over the housework. Claire achieved a mastery over her environment through illness which she never attained through health.

At 19 she married a fairly prosperous and healthy man. "Maybe it was to get out of the house, I don't know." She was happy and felt wonderful. Then things began to happen. An aged man stepped in front of their car and was struck down. After several months in the hospital he died. During this time she called or visited the hospital daily. Her husband lost his business. He developed a serious peptic ulcer which necessitated hospitalization. She thought he was going to die. "It was just like waiting for my mother to die all over again."

Claire gave birth to a puny baby that never ate, and she was afraid that she was going to lose her. "After marriage nothing improved. I was the same housemaid but had more worries."

Finally the husband got well and the baby began to eat. Her father suddenly died. It was at this time that she developed her migraine attacks.

Since the onset of her headaches, she has run the gamut of roentgenograms, electroencephalograms, neurologists and special headache clinics. She has finally been convinced that she does not have a brain tumor.

An actor does not play to an empty house, and Claire has her audience—her husband, her daughter and her friends. Her daughter calls her once or twice every day and her husband calls her every day. She knows where she can reach them at any time. (She will never again have to knock on the wall to attract a neighbor if she should become suddenly ill.) She has a large group of friends and belongs to several charitable organizations. She consequently has an active social life. Her friends are so accustomed to her indispositions that they call her before each function to make sure she is not *hors de combat*.

Claire came under my care some eight months ago, during which time, I have been seeing her twice weekly. She has finally relinquished her headaches. During her therapy she developed and has been cured of her fears of breast cancer and diabetes in rapid succession. At present she is toying with some obscure gastro-intestinal pathology—but only in a half-hearted manner.

As a child the only way in which she could win love and understanding was by the use of illness; as an adult she still achieves her goal through this archaic style of life. She said to me plaintively during our first interview, "My sister, who lives next door, doesn't even know if I'm alive. She never visits me unless I have a headache." Her headache had further function in that it expressed anger and guilt concerning her father. During therapy she told me how she had often wished him dead during her childhood and then felt consumed with guilt. At another time she said, "I wish he were alive so I could call him a bastard."

So Claire remains queen and her subjects pay her obeisance. But she can keep her shaky throne only through illness. As a child the only time she was ever loved or understood was when she became ill. As an adult she is still trying to achieve her goal through illness. According to the Adlerian concept, her illness has the function of achieving superiority over her environment. When she is well she is the ignored. When she is ill she receives attention and consideration. She is the Group One patient who has no demonstrable organic illness.

Let us now consider the group two patient.

Case 2: Harry L., 52-years of age, is male, a hardware salesman. He is married and has two daughters. He is an anxious, symptom-laden person who has worked hard all his life. He came from a slum area, had lost his mother when he was very young and had been brought up by his grandmother. He was the second of three sons. The oldest has been in a State Hospital since the age of ten because of schizophrenia. The youngest is a bachelor of 45 who is a recluse.

Harry literally pulled himself up by his bootstraps. He bought a small hardware store and by working fourteen to sixteen hours daily for many years achieved a moderate degree of success. About eight years ago he sold his business, invested his assets and decided he could get along on the $90 per week he coud earn as a salesman. During these years he spoke con-

stantly of retirement although he could never realize this goal with the moderate income he had.

During his maturing years he became quite self-centered and demanding. He was the head of the family and his wife and daughters knew it.

About eighteen months ago he was hospitalized for a mild coronary condition. Under ordinary circumstances this should have kept him from his fairly sedentary job for not more than twelve weeks. Since the attack occurred on the job, it was called compensable by the Labor Department and he was awarded about $35 weekly. With other insurance, he receives about $60 weekly. This is not quite enough for his needs. The next act is about to unfold. He is conveying the idea to his wife that she should get a part-time job. His wife is his inferior intellectually and Harry has made her aware of this. She is constantly occupied with attending to his needs. This is her insurance against getting a job. In this way, she is as clever as he is. He gets up late, goes to bed early, takes an afternoon nap and is in a constant fret about his inability to sleep. He characteristically walks about very slowly as though each step brings him closer to the grave. His hand frequently is placed, not on, but just below the heart region. He makes use of a non-aggressive trait, anxiety, to place him in a commanding position.

Through his fear of illness, he exploits all those about him, as well as the insurance companies. He even tries to exploit me by attempting to see me at times convenient for him, for help in filling out the various forms required by the insurance companies. Unfortunately, Harry has to pay for his success. Since, in our society, there is no place for drones, he has to have a good reason for not working. Consequently, he has developed many psychosomatic symptoms—hives, headaches and especially chest pains while at rest. Occasionally, a well-meaning friend will ask him if he wants a job or if he is ready to go back to work. When this happens it is invariably the signal for the exacerbation of pain. That night (his wife reports to me), he feels worse. Repeated electrocardiograms, blood tests and examinations are negative, but his pain is just as real as though it were based purely on an organic illness.

Here again we see illness with a purpose. Through it he is able to achieve his goal in life—early retirement. His life style is that of the demanding personality. In this way he masters and finally exploits his environment. In Harry we see another type of psychosomatic case illustrated. His symptoms are caused by emotional factors with an organic substrate to give them respectability.

Case 3: Betty D., aged 70, baby-faced, blond, petite, pert, and sweet, is an example of the group three patient. She looks 55 and thinks she looks 45. She has been a widow for the past 40 years. She has earned her own way since the death of her husband. At present she is doing clerical work and she says, "everyone in the office loves me."

About 15 years ago she came to me with a history of recurrent asthmatic attacks. She was skin tested and I found her to be allergic only to dust. Betty was desensitized to dust and injected with vaccines to build up her immunity to respiratory illness. As each new antihistamine and steroid was introduced we tried it on Betty. Her attacks were particularly frightening since she has no living relatives and lives alone. The vasomotor nervous system has an overlapping function—both organic and emotional—and since we were attacking only the organic aspect of her illness, the results were questionable. Her treatment, or possibly some friendly words, gave some results.

Several years ago when I began to bring a psychiatric orientation to my practice, I suddenly realized that her attacks began to exacerbate at the beginning of November, reached a climax during the Christmas vacation, and began to subside about the middle of January. She had mild asthma during the year but it was during the holiday season that the real attacks occurred. It suddenly became apparent that she was celebrating more than Christmas at this time of the year.

She told me about her husband, the ideal mate. Here was truly a love match. He idolized her. We are all familiar with the ritual of carrying the bride across the threshold on her wedding night. In Betty's life it happened every evening. When he came home he would ring the bell and she would come outside the door so he could carry her across the threshold each night. He called her "Betty Baby." He decided she was too cute to have children—it would spoil her figure, and they were ever so careful. She told me how much she loved him. The deeper her love became, the worse her asthmatic attacks became. He learned to give her adrenalin injections each time she had an attack.

Finally, in November, he developed an acute myocardial infarction. He seemed to be convalescing nicely when he suddenly died during Christmas week. In describing his death to me

she said, "When I realized that he was dead, the very first thing which occurred to me was, who will give me my adrenalin injections? Wasn't that awful—to think of myself at a time like that?"

For the next five years Betty did not have any asthma attacks at all. After this time the cycle of asthmatic attacks, as I have described it, began.

The psychodynamics of this case are self-apparent. She had been denied her rightful heritage as a woman and potential mother. She was doomed to remain a baby doll and perpetual bride—a role she is having great difficulty fulfilling at the age of seventy. She had developed a dependent style of life. This style of life helped her choose a domineering husband who destroyed her with kindness. She became more dependent with the active collaboration of her husband. But she was thrown into conflict by being completely infantilized by her husband and by not having children. She did not like the role assigned to her and her reaction was a suppressed rage. She could express this rage only by using the language of the body. The asthma was actually an expression of anger at her husband.

I believe the asymptomatic five years occurred because the source of her anger had been removed. She also had to leave the world of make-believe, face the facts of life, give up her asthma and begin to work productively. She had to become, in fact, a real woman; and she did.

Why the asthma reoccurred after five years we can only surmise. Perhaps as she grew older she again realized how impoverished she had become without children and there was a reawakening of her anger at her husband. There certainly was a large element of guilt because of her preoccupation with her own needs at the time of his death. We can hardly blame her for her selfishness since her husband brought her up that way. Some guilt feelings were probably based on repressed death wishes toward her husband. And for her guilt feelings she had to do penance by having asthmatic attacks on the anniversary of his illness and death.

Betty's illness was teleologically adequate to express her anger against her husband and finally to expiate her guilty feelings. She could attain superiority over her environment through the use of certain character traits which constitute her style of life: vanity, anxiety, hate, dependency. She was the avoiding type.

Betty attained insight into the reasons for her seasonal asthma and at present she has not had a real attack for two years. Her illness is generally considered organic and has to do with the autonomic nervous system.

All three cases demonstrate the application of Adlerian principles to the understanding of psychosomatic illness. It is through the inferior organ, the *locus minores resistentiae* that the body expresses itself. The psyche speaks through the body by means of the autonomic nervous system and the endocrine system—blushing, sweating, trembling, enuresis. Organ language expresses the attitude of the individual toward the problem confronting him. Each day we hear these colloquialisms: a pain in the neck; something I can't swallow; it eats me up alive; my heart is heavy. They refer to tension headaches which characteristically start along the neck muscles; globus hystericus; neurogenic vomiting; peptic ulcer; pseudo-angina. The body speaks a language of its own. The language it speaks depends upon the individual psychology one has attained in his struggle with the environment.

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Psychological Reactions of Patients to Surgery

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There is no doubt that surgery has reached a stage where the surgeon is no longer merely a technician. If the surgeon of today fails to realize the importance of the surgical patient as a psychosomatic human being, he is not entitled to be called a modern surgeon. In days past, the surgeon concerned himself with the technical aspects of surgical operative procedures. Others of his colleagues made the diagnosis and prepared the patient for surgery. Then came the era of the various influences in surgery and new terms appeared in surgical texts and new words were spoken at surgical conclaves.

Successively, surgery passed through the developmental phases of surgical anatomy under the aegis of John Hunter. Then the master pathologists, Rokitansky and Virchow compelled surgeons to think in terms of surgical pathology. Today the field of surgical physiology and physiological chemistry hold sway and the cynosure of surgery is cardiovascular procedures. As of now there are only a few surgeons who have concerned themselves with the psychosomatic approach to surgery.

My own awakening to the importance of this aspect of modern surgery occurred many years ago. At that time, I was a resident surgeon at Kings County Hospital Center. The following case history was my first introduction to the necessity for a knowledge of psychosomatic problems in surgery.

At the age of nineteen, a young woman had her first attack of pain in the abdomen. On her twentieth birthday she had an appendectomy. Six months later, she had a pelvic operation for dysmenorrhea. At twenty-six she had her third operation for abdominal adhesions. For the next four years she complained more or less constantly and was confined to bed for many weeks at a time. Finally she was seen by a kidney specialist who treated her for an obstruction in the urinary tract. After entering the hospital, a fourth operation was performed for what was believed to be some disease of the large intestine. At that time operation failed to reveal any organic pathology.

Here, then, was a patient who had been incapacitated for many years and who, during that period of time, had been repeatedly subjected to searching physical examinations and four abdominal operations. What the many physicians attending her had not discovered, or did not understand, was that the first of these many illnesses began shortly after the fourth of her five sisters had married, and this patient thought that she would remain a spinster and fall into the well of loneliness. Meek and submissive, unattractive and not too intelligent, she unconsciously turned to illness as an excuse for not being able to compete with her sisters. Further personality studies disclosed her very immature emotional development, and confirmed the opinion that the sisters' marriages had precipitated an invalid reaction in this psychoneurotic individual. Her initial complaint of pain in the abdomen was accentuated in order to attract attention to herself. Here is an example of the surgeon using his scalpel when he should have employed the services of a psychiatrist.

The modern surgeon must consider his patient as a human being and not as a "case" (gall bladder case, gastric case, etc.). He must know his patient before the operation and after. It is only by previous knowledge of an individual and by constant observation, that many unnecessary operations can be avoided. The surgeon, who operates on all his patients indiscriminately, is dishonest. He is dishonest to himself, to the patient and to the medical profession.

It has been known for many years that emotional disturbances often accompany dysfunction of the thyroid gland. The disorders of the thyroid gland are among the most disturbing diseases encountered by a surgeon. When this gland functions ex-

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cessively the patient will lose weight, become nervous and may complain of palpitations of the heart. The emotionalism of hyperthyroidism is a very significant feature of the disease. Following adequate treatment, with recovery from the disease, the emotionalism will diminish and often disappears. In many instances the services of a competent psychiatrist are necessary before and/or after thyroidectomy.

The rise in specialization has driven doctors to concern themselves only with their own duties in the vast field of medicine. Thus the specialist in many instances loses sight of the patient as a psychosomatic entity; the doctor, therefore, frequently treats only a region of the body when he should consider the patient as a human being with many mental faculties.

A surgeon may perform a procedure, necessary for the preservation of life, but which may cause psychic trauma of sufficient severity to alter the social pattern of the individual concerned. The day has passed when the surgeon's duty terminates in the operating room. This is especially true in the management of patients upon whom a colostomy has been performed for some pathologic condition of the colon or rectum.

To awaken from an operation and find oneself having bowel movements through an opening on the abdomen is valid cause for consternation. Confusion reigns when it is realized that the defecation reflex has been disturbed or is absent. A normal bowel habit has a very salubrious effect on patients, and its enjoyment is a normal expression of a healthful physiology of the gastrointestinal tract. For this reason the sudden loss of a frequently used physiologic process must of necessity give rise to disturbing mental reflections.

Unfortunately, patients of this type rarely fall under the care of psychiatrists for guidance. Commencing as a surgical problem, they remain one and continue to be seen and treated by the surgeon alone. If the surgeon is short sighted he will see only that portion of his patient upon which he performed surgery. Simple friendly conversation will bring to light the mental trauma produced when a colostomy is performed. Discovery of this trauma will enable the surgeon to adopt measures for combating this disquietude. By so doing he will assuage the grief associated with the performance of a colostomy.

Another disturbing phase of surgery for the patient is the fear of surgery. If a patient has an abnormal fear of a surgical procedure, it is best not to undertake surgery. When a patient tells me he is "frightened to death," I postpone all surgical procedures until the patient returns for the operation by his own decision. My one regret has been that in the early days of my surgical career I failed to realize that when a patient told me he was going to die under anesthesia I did not believe him. He died and now I am a confirmed believer in psychic traumatic shock.

Conclusion

The surgeon of yesterday little realized that posterity would demand a knowledge of psychiatry in modern surgery. Today, in the diagnosis and cure of many surgical patients, the surgeon must trespass on the confines of the psychiatrist. Although in the past, the surgeon did not consciously enter his domain, it cannot be denied that he often pierced the outskirts of this realm. The surgeon of today has been made aware of the existence of psychosomatic problems in surgery. Modern surgery and modern dynamic psychiatry are as closely allied as any other medical specialties, and they must march side by side in the rapidly advancing battle against human diseases.

Notes and Comments

The 1960 Academy Meeting

The recent meeting in Philadelphia was a noteworthy event in the history of the Academy of Psychosomatic Medicine. Papers presented were of exceptionally high educational caliber, and the truly interdisciplinary exchange of ideas made for a memorable three days.

Next year's meeting will be held in Baltimore, Md., from October 12 to 14, 1961. In order to make this one even better, it is suggested that you send in your comments and critique of the Philadelphia sessions. Which lectures, panels or symposia did you find most valuable? Why? Which did you find least valuable? Why? What would you suggest for next year's program? Did you find the discussion groups worthwhile? Do you favor more spontaneous panels or do you prefer more structured lectures?

It is only through your expression of your needs that the program committee can hope to meet them. Letters sent to the Editor will be published if sufficiently provocative. All comments will be forwarded to Dr. George Sutherland, the 1961 Program Chairman.

Please note that Dr. Milton Cohen, chairman of the Tape Recording Committee is preparing tapes of the meeting and these will be available shortly. If you will write to the editor indicating which sessions you would like to have for your files they can be ordered at once. The estimated cost is approximately $10.00 per tape.

Membership Drive

The Academy membership has climbed steadily in the past seven years. Starting with approximately 64 members in 1953, the last figures placed the total at almost 800. If each member will make an effort to get at least one new member, it will not be difficult to reach the current goal of 1500 members. It is only then that our efforts to expand the journal will be financially possible. If you know any physicians to whom you would like to send a complimentary issue of the journal as introduction to the Academy, send their names to the Publication Manager, Mr. Stanley Kaish, c/o *Psychosomatics*, 277 Broadway, New York 7, N. Y.

Academy News Notes

DR. SANFORD M. LEWIS, Physician-in-Chief, Psychosomatic Clinic, Presbyterian Hospital Unit, United Hospitals of Newark, delivered a paper on "Psychosomatic Factors in Constipation" before the Annual Meeting of the Medical Society of New Jersey in May. He spoke also before the Dental Section, Academy of Medicine of New Jersey in June on "Psychosomatic Formulations in Dentistry." Articles based on these remarks will be published in forthcoming issues of the *Journal of the Medical Society of New Jersey* and the *Journal of the American Dental Association* respectively.

DR. LOUIS F. BISHOP recently took office as President of the American College of Cardiology.

DR. JOSEPH JOEL FRIEDMAN has been elected to membership in the Society for Clinical and Experimental Hypnosis and has been certified by the American Board of Medical Hypnosis. He was appointed Research Fellow in Psychiatry at Brooklyn State Hospital effective September 1, 1960.

Notes on Postgraduate Training

Postgraduate training for the non-psychiatrist has become a reality in many areas of the country. In some instances, the training is a short two or three day continuous program, while others present weekly seminars. Some of the medical centers and groups offering this type of instruction include: The University of California, San Francisco; the California Medical Society, Los Angeles; the Illinois Academy of General Practice, 14 E. Jackson Blvd., Suite 1512, Chicago; the Central Maine General Hospital at Lewiston; Wayne State University, Detroit; Hahnemann Medical College, Philadelphia; Temple University, Philadelphia; the University of Colorado, Denver; the University of Nebraska, Omaha; the University of S. California, Los Angeles; the American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill.; the University of Texas, Houston; the Mental Research Institute, Palo Alto, California; the Langley Porter Neuropsychiatric Institute, San Francisco; the North Shore Hospital, Winnetka, Illinois; the University of Kansas, Kansas City; The University of Michigan, Ann Arbor; the Lafayette Clinic, Detroit; The New York Academy of Medicine; The University of Pittsburgh; the University of Tennessee, Memphis; and the University of Washington, Seattle.

Members of the Academy and subscribers to *Psychosomatics* who attend any of these courses (or others not listed) and are inspired to describe their experiences, are invited to submit short summaries to the Editor for publication. Perhaps, in this manner, others can be alerted to their value.

Coming Meetings of Interest

Eastern Psychiatric Research Assn., Creedmoor State Hospital (Nov. 3) and Waldorf-Astoria Hotel, New York City (Nov. 4 and 5, 1960).

American Medical Writers' Association, Hotel Morrison, Chicago, November 18 and 19, 1960.

Academy of Psychoanalysis, Hotel Biltmore, New York, December 10 and 11, 1960.

American Academy of Allergy, Statler Hilton Hotel, Washington, D.C., February 6-8, 1961.

American Academy of General Practice, Miami Beach, Florida, March 6-9, 1961.

American Orthopsychiatric Association, Sheraton-Hilton, New York, March 23-25, 1961.

National Health Council, Waldorf-Astoria, New York, March 23-25, 1961.

American Academy of Neurology, April 24-29, Sheraton-Cadillac Hotel, Detroit, Mich.

American Psychosomatic Society, April 29-30, 1961, Atlantic City, N. J.

Recent Items and Reports

The Mental Health Committee of the Illinois Academy of General Practice is presenting its Second Annual Seminar-Discussion course entitled "Office Management of Emotional Disorders." The course will be given at the Lutheran General Hospital, 1775 Dempster St., Park Ridge, Illinois. Physicians may register now for the second portion (February 1, 1961-June 21, 1961) by sending $30.00 to Bertram B. Moss, M.D., Chairman of the Mental Health Committee, c/o Illinois Academy of General Practice, 14 E. Jackson Blvd., Chicago 4, Ill.

*

The family doctor can treat a vast majority of the milder senile psychotics by providing a listening post that they can find nowhere else. Psychiatric treatment may not be essential, according to a report by Dr. Jack Weinberg, Clinical Professor of Psychiatry, University of Illinois, who participated in a resent Institute on Rehabilitation of the Aged, held in Dallas, Texas. (Quoted from *Factor*, Vol. I, No. 9.)

*

Neurokinin, a polypeptide with vasodilating properties, has been implicated in various disorders of the central nervous system. Excessive production is a result of an inappropriate adaptive response, as seen after extraordinary effort of frustration. Drs. Harold G. Wolff and Loring F. Chapman of Cornell University Medical School feel that neurokinin may be implicated in such states as migraine and schizophrenia.

*

Wayne University in Detroit, Michigan, recently inaugurated a television-radio course in "Psychiatry and Medicine."

Treating the Patient as a Hole

(Continued from page 247.)

must have some additional factor operating within him: this is most likely to be a hidden infection; a hormonal disturbance such as hyperthyroidism, pituitary disease, or pregnancy; or an emotional upset. Further studies usually reveal the nature of this factor. However, it is absurd to start with the assumption—implied in "comprehensive medicine"—that all patients with diabetes mellitus must have a serious emotional disturbance that requires meticulous investigation and intensive treatment.

Naturally every person who discovers that he has a disease is likely to be somewhat concerned, or even upset. This condition is usually ameliorated quickly in nonfatal diseases by brief statements about the prognosis and about what treatment will do. A physician's appearance of confidence, or at least a demeanor that suggests that he understands and is in control of the situation, is more likely to relieve the patient's concern than long-drawn-out discussions of how the body's physiology handles the disease in question and how emotion influences its course.

Sick people and their families should obviously be treated with consideration. This does not mean that the physician must assume a simperingly-sweet demeanor that is foreign to him. One outstanding practitioner was known for his even temper—it was continually bad. Nevertheless, he showed by his actions that he was devoted to his patients, and as a consequence they were devoted to him. The physician who handles his patients with consideration is practicing good medicine. On the other hand, the one who does not take the time to elicit a thorough history but instead rushes through a lot of tests—some of them uncomfortable and expensive—not only is being inconsiderate but also is practicing poor medicine. However, it does not follow that he is being inconsiderate *because* he uses laboratory tests unwisely. Both his misuse of the tests and his inconsiderate handling of patients are manifestations of his poor quality as a physician: he does not understand laboratory medicine any better than he understands nonlaboratory medicine.

There is no separation between laboratory and nonlaboratory medicine. Each has its proper place in good medicine—a place learned by training and experience and not by listening to exhortations to "treat the patient as a whole." The idea that man is different in some ways from the sum of his parts is mystical nonsense. The competent physician always treats whatever parts need treatment after studying all of them.

M.D.A.

Abstracted from the Medical Press

THE HAPPY COLLEGE STUDENT MYTH. M. L. Selzer, Arch. Gen. Psychiat., 2:131-136, 1960.

Culled from the 3,000,000 student body of 1,900 colleges in the United States, Dr. Selzer has accumulated statistics to disprove the almost universally accepted impression that the average college student's mental health difficulties are less serious than those of persons in the general population.

A total of 506 students in the University of Michigan were interviewed in the Mental Hygiene Clinic by three psychiatrists. Of these, 40% were self-referred; physicians referred 29%, and 9% were referred by the faculty. Diagnosis showed that 35.4% were psychoneurotic, 24.5% had personality disorders and 21.7% were schizophrenics. Some 8.3% were included in adjustment reactions.

As a closing remark, I quote Dr. Selzer: "here is reason to believe that patients seen by a college health service psychiatrist are diagnostically comparable to patients encountered in any outpatient psychiatric clinic accessible to the general public."

Leo Wollman, M.D.
Brooklyn 24, N. Y.

PRACTICAL PSYCHOTHERAPY—A VALUABLE TOOL OF ALL PHYSICIANS. Franklin S. DuBois, M.D., Conn. Medicine, 24:7, July 1960.

Since there are too few psychiatrists to treat the rising tide of emotional sickness, the major part of psychiatric work in any community can and should be done by the non-psychiatrists. The author outlines a practical method of psychotherapy which can be used to attack the basic emotional problem, anxiety. The physician is primarily a teacher when he uses prophylactic psychotherapy; he attempts to preserve the home, prevent inconsistency and rejection in parental attitudes, and helps promote tolerance and understanding.

Remedial psychotherapy is basically re-education and should be directive. After the problem has been adequately ventilated and the patient's strengths and weaknesses assessed, reorganization of his life may be attempted by utilizing the strengths and minimizing the weaknesses.

F. W. Goodrich, Jr., M.D.
New London, Conn.

THE PSYCHIATRIC TREATMENT OF OFFENDERS. New York Med., Vol. XV, No. 24, December 20, 1959

In an attempt to meet the problem of delinquency, our community is seeking the assistance of medically-trained minds. One figure in medicine prominently involved in this area is Dr. Melitta Schmideberg. Through her efforts, the "Association for the Psychiatric Treatment of Offenders" (APTO), was established. This organization fills a tremendous need. On the occasion of this report, the group met with representatives of the law, probation, correction and social workers interested in the offender.

The chairman, Prof. Herbert Block, introduced "The Magnitude of the Problem." Besides mentioning that delinquency is on the rise, curiously more so in the democracies, he emphasized the regrettable fact that its incidence is "moving down into the lower brackets." All speakers recognized the emotionogenic factor in crime and complained about the pitiful lack of psychiatric facilities available for the diagnosis and treatment of the delinquent and for the training and supervision of workers in the field. Julge Peter T. Farrell observed that in order to understand the motivation of the criminal act, criminal justice is in need of intensive help from psychiatry, since no longer is it exclusively the bad and the deprived who appear before the court. To the roster are added those who come from superior family and environmental backgrounds. He recognized that the glib use of incarceration and punishment are not constructive and appealed for more clinics for guidance. Fastov, representing the Correction Department, pleaded for the reduction from the "giant" institution to one of smaller size to provide more individual care. Edith Schwartz (social worker), defined the friction of the court clinic in diagnosis and assignment. The mention of the tremendous case load social workers maintain rings a familiar problem. Her reference to the need of the probation officer as a symbol of authority is emphasized and should be heeded by all concerned.

Dr. Schmideberg then followed with an analysis of the inadequate facilities, observing that most psychiatrists reject the criminal fringe. She insisted that special training in criminosis is needed for those who have the interest and the capacity for research and experiment. A useful differential diagnosis between the neurotic and

the offender was presented by the Department of Clinical Services of APTO. The offender is described as a community problem because he induces suffering in others and lacks those qualities of awareness and cooperability to seek help. In discussing criminal psychiatry, this department recommended special training for therapists, claiming that classical psychoanalytic therapy is ineffectual because of the absence of inner suffering. The philosophy of treatment rests upon reeducation and socialization, which includes the release from destructive tensions and the building of inhibitions. The authority and support of the court is often essential for continued treatment.

Ruth Ochrock, Ph.D., APTO therapist, indicated that therapy revolves about "reality confrontation" and correction of the self-concept with "old-fashioned tact" and support.

A second section of the symposium is devoted to an equally complex subject, "Psychiatry and the Law." Judge Farrell protested that the philosophy of responsibility is being challenged by the philosophy of excuse, with Society standing accused. Judge Timone said he was of the opinion that immature psychiatric recommendations might invade the civil rights of a defendant and deprive him of "due process of law" and "confrontation of cross-examination." Of course these points require clarification. Dr. Schmideberg attempted to do so. She reassured the justices that psychiatry cannot replace the law nor substitute for morality and proper upbringing. Nevertheless, to her, psychiatry is a mercy "that tempers justice" as a "privilege rather than a right." As usual, the matter of "free will" complicated the issues. Cases obviously psychotic or with grave disturbance or stress, Dr. Schmideberg observed, are unanimously recognized as not responsible. But for others, the law is essential and the social code is a standard of acceptable behavior. This section reflects on both the conflicts existing between law and psychiatry and the justifiable concern of the judiciary lest they should happen to overlook a "patient." It also raises the question of degrees of involvement of unconscious motivation and how to translate these concepts to satisfy the law. Moreover, how is one to deal with the presence of cerebral dysrhythmia in certain offenders and interpret their responsibility? Currently, in New York State, a strong attempt is being made to clarify the contributions of both law and psychiatry to bring about a better approach to the problem of delinquency.

The material contained in this paper is readable and informative for all physicians. A glimpse of the problems of law and psychiatry is provided and it acquaints one with the creditable work of APTO. It is highly recommended reading.

George J. Train, M.D.
Brooklyn, N. Y.

NUCLEAR SEX AND BODY-BUILD IN SCHIZOPHRENIA. V. Cowie, A. Coppen, and P. Norman, Brit. Med. J., Aug. 6, 1960: 431-433.

One hundred male and one hundred female mental hospital patients with a diagnosis of chronic schizophrenia were measured for biacromial and bi-iliac diameters. The purpose of the research project, which was financed by a grant from The Medical Research Council, was to verify or disprove a recent survey on body-build which showed that schizophrenics differ markedly from normal subjects with regard to the biacromial diameter and the androgyny score. The androgyny score is obtained by the formula: 3x biacromial diameter (cm.)—1x bi-iliac diameter (cm.). The androgyny score for normal males shows a mean of 90.1 and for females a mean of 78.9. This permits an effective discrimination to be made between the sexes. The biacromial diameter and the androgyny score are closely related to sexual development. There is reason to believe that a connection exists between anomalies of nuclear sex and mental disorders.

Buccal mucosa scrapings and smears of capillary blood from the ear were utilized to assess nuclear sex. No anomalies of nuclear sex were discovered. The authors' conclusion: "It seems improbable, therefore, that nuclear-sex anomalies are associated in any significant degree with schizophrenia, or that they are responsible for the marked differences in body-build between schizophrenic patients and normal individuals."

Leo Wollman, M.D.
Brooklyn 24, N. Y.

HYPNOSIS—APPLICATIONS AND MISAPPLICATIONS. Harold Rosen, M.D., Ph.D., J.A.M.A., Vol. 172, No. 7, Feb. 13, 1960.

Hypnosis will, in all probability, turn out to be a potent medical research tool. The techniques are easily taught and learned. About 25% of the general population may be hypnotized. It is important to know when not to hypnotize a patient. The motivations of the patient should be determined.

Long term studies do not confirm short term hopes. Short courses in hypnosis are growing in popularity and are concerned chiefly with these short term hopes. Psychotic depression may be precipitated.

The self-styled hypnoanalyst without years of psychiatric training can be dangerous.

Pain is a symptom which frequently drives a patient to a hypnotist. Emotionally based pain frequently masks severe and even suicidal depressions.

Borderline psychotics may be hypnotized. Unless they are recognized as compensated psychotics, suggesting away a single symptom may break down this last defense against decompensation.

No one, ignorant of psychodynamics, should ever treat patients on hypnotic levels beyond the range of his usual professional competence with unhypnotized patients.

Joseph Joel Friedman, M.D.
Brooklyn, N. Y.

CLUES SUGGESTING EMOTIONAL DISTURBANCES IN CERTAIN DERMATOSES. Sadie H. Zaidens, M.D., N. Y. St. J. Med., 60:2874-2876, Sept. 15, 1960.

This short article is well worth the reading, as in recent years it is becoming increasingly evident that the patient's derma may reflect an underlying emotional conflict. The author points out that "in many skin diseases a careful study of the patient's personality as well as of the skin disorder may show evidence of an emotional disturbance. An evaluation of the patient's emotional reactions to therapy is important to the treatment. Some of the signs and symptoms a physician should look for are: reticence or difficulty on the part of the patient in making an appointment; an unusual history; atypical eruptions; undue or unrelated symptoms; and the erratic behavior, bizarre appearance, and antagonistic or ambivalent reaction to therapy and to the physician on the part of the patient."

James L. McCartney, M.D.
Garden City, N. Y.

SHAMANISM. Arthur G. King, Obstetrics & Gynecology, 16:1, July 1960.

Doctors are "functional descendants of the shamans who specialized in healing the sick." One of the most important aspects of this heritage is the blind faith which our patients have in us because of our position as modern shamans. As knowledge increases and people become more sophisticated, this faith is apt to be shaken. It is important that we nurture this confidence rather than abuse it. Unnecessary surgery or the use of the latest fad in medication, when we ourselves have doubts about the real therapeutic value of such treatment, is an abuse of the patient's faith. We can retain the faith of the public "only by rising to the level of intellectual, psychologic, and social development which the rest of the people have reached. Let us be more discriminating in our medical beliefs; and let us be more honest with both patients and ourselves."

Frederick W. Goodrich, Jr., M.D.
New London, Conn.

TECHNIQUES OF HYPNOSIS. William S. Kroger, M.D., J.A.M.A., Vol. 172, No. 7, Feb. 13, 1960.

Methods for inducing hypnosis are direct, indirect or mechanical. Preliminary testing for patient's susceptibility is simple and advisable. All therapists must be capable of switching from one approach to another, even during the same induction. Proper motivation and instruction of the subject beforehand; a confident approach by the hypnotherapist; and a healthy rapport makes induction much easier and the therapy more fruitful.

Hypnotic induction can be readily learned but this is only the first step. Much clinical experience is needed to gain proficiency.

Hypnosis should be employed only by doctors for specific purposes in selected patients. These doctors should realize their limitations and not exceed their psychotherapeutic orientation or ability.

Joseph Joel Friedman, M.D.
Brooklyn, N. Y.

HYPERVENTILATION FROM ORGANIC DISEASE. P. R. Aronson, Ann. Int. Med., 50:554-559, 1959.

Cardiovascular, intrathoracic and other disorders may be the cause of the hyperventilation syndrome. The frequent association of anxiety with the latter diagnosis may produce difficulties in differential diagnosis. Among the organic possibilities are: coronary artery disease, pericarditis, dissecting aneurysm, cardiac arrythmia, pulmonary hypertension, pulmonary emboli, esophageal disorders, hiatus hernia, Tietze's syndrome, fibromyositis, intercostal neuralgia, cholecystitis, splenic flexure syndrome, cervical arthritis, herniated disk, herpes zoster, collagen diseases and salicylate poisoning.

The author stresses the importance of a detailed history, in which the sequence of the appearance of the symptoms is stressed. Electrocardiograms and roentgenograms are needed not only to evaluate the presence of organic disease but are also necessary for reassurance.

DIAGNOSIS AND TREATMENT OF BEHAVIOR DISORDERS IN CHILDREN. G. J. Lytton, M.D., and M. Knobel, M.D., Dis. of the Nerv. Syst., 20: 334-340, August 1959.

This paper discusses the hyperkinetic syndrome and behavior disorders in general and presents

the results of a study of the action of methyl phenidate (Ritalin) in this type of problem.

The authors postulate a psychoneurological point of view rather than a purely psychogenic one in their understanding of the cause of the behavioral problem.

As to the action of methyl phenidate, there seems to be strong evidence that the effect may be due to direct action on the cortex as well as through subcortical structures. The dosage varied from 15 to 200 mg. daily. It was felt that in 15 of 20 patients a definite improvement was obtained.

RECENT CONCEPTIONS AND MISCONCEPTIONS OF SCHIZOPHRENIA. S. Arieti, M.D., A. J. of Psychotherapy, 14:3-29, Jan. 1960.

The author readily admits at the outset that our knowledge of schizophrenia is far from complete and attempts to review and evaluate current specific psychologic theories. He omits the organic theories "because he does not subscribe to them."

In Bateson's theory of the "double bind," the child is exposed repeatedly to situations and messages that are double bind; for instance, the mother tells the child, "Pull up your socks," and at the same time her gesture implies, "Don't be so obedient." In this atmosphere, the child is damned if he does and damned if he doesn't. The author, in his critique of this theory feels that double bind situations are characteristic of man, not of schizophrenia, since we are all exposed to them.

In Szasz's theory, in which schizophrenia is due to a "deficiency of incorporated objects," the patient has no models to use in his life. He is awkward and inadequate. The author feels that this theory is also difficult to accept because the history of the pre-psychotic denies such poverty. Instead there is a vulnerability or fragility of the organization of social symbols and internal objects caused by the emotional conditions under which they took place.

As to the contributions of the existentialist school of psychiatry, which is particularly concerned with the "here and now," the therapist is not concerned with why the patient became psychotic but with how it occurred. The author feels that this is tantamount to looking at only the top of an iceberg and not being aware of the greater portion which lies under water.

CONTEMPORARY CONVERSION REACTIONS: A CLINICAL STUDY. F. J. Ziegler, et al., Am. J. of Psychiat., Vol. 116:901-910, April 1960.

This is a report on the records of 134 consecutive patients diagnosed as conversion reactions who were seen in consultation at the Johns Hopkins Hospital during the last four years.

Patients illustrating classical conversion symptomatology simulate organic disease processes as they conceive them. Some patients are "expert simulators," especially those who are medically sophisticated. The type of symptom most often simulated was that of pain, which is often the somatic representation of an affect. A factor in shaping symptoms, in addition to identification and simulation, is that of symbolic transmutation of specific unconscious conflicts and affects.

Depressive features were present, although overshadowed by conversion symptoms, in 40 of the 134 patients. Conversion symptoms may be used as defenses against more overt depression. Nineteen patients showed clinical evidence strongly suggestive of an underlying or incipient schizophrenic process. In a large number of patients the standard formulation of conversion as a defense against potential neurotic anxiety seemed to apply.

Phenomenologically, conversion reactions in general enable the patient to avoid or reduce affective distress by substituting fantasy-induced and symbolically expressed somatic distress or dysfunction. In this way an intolerable affective problem may be converted into a face saving physical-medical one, in which the patient shifts the responsibility for remedial action from himself to others, including the physician.

The refractoriness to psychotherapy usually took the form of continued insistence that their problems were physical and not emotional. Any obvious anxiety or depression was rationalized by the patients as secondary to alleged organic diseases. Most of the patients refused psychotherapy even on a tentative trial basis.

PSYCHOTHERAPY. Kenneth E. Appel, M.D. J.A.M.A., Vol. 172 (13): 1343-1346, March 26, 1960.

Psychotherapy is widely misunderstood; it is not a transfusion of ideas to the patient nor is it an injection of correct notions or soothing platitudes. It is not making decisions or solving problems for the patient. It does not preclude the use of drugs; drugs may facilitate psychotherapy. It is a collaborative search for a better adjustment for the patient; it is helping him to develop solutions, capacities and confidence through discussions, guidance, talking things out and the release of pent-up feelings.

Physicians and surgeons will be called on to do more psychotherapy than ever, since the introduction of the new tension-reducing drugs.

Various methods of psychotherapy are available to the general physician: 1) aeration or ven-

tilation; 2) supportive psychotherapy; 3) manipulative psychotherapy (occupational therapy, hobbies); 4) explanatory psychotherapy (desensitization, persuasion and reeducation); 5) dynamic growth therapy (mobilization of the interests, assets and resources of the patient to enable the patient to expand, take the initiative and develop).

"One of the essential qualities of the clinician is interest in humanity, where the secret of the care of the patient is in caring for the patient."

TRIFLUOPERAZINE (STELAZINE) IN ANXIETY STATES. F. R. Souder, Antibiotic Med. & Clin. Therapy, 6:711, 1959.

In a study of the use of the drug in 142 outpatients, a lessened anxiety was noted within one week in 118 patients. Its greatest value lay in the reduction of the emotional overlay in those with concomitant physical disorders. Failures were seen in those instances where the symptoms provided secondary gain. The dose employed was 1-2 gm., two to four times day.

CHRONIC SUBDURAL HEMATOMA. M. Depaus, Semaine des Hopitaux, 35/52:3028-32.

A latent period of weeks or months occurs before patients develop headache, psychic changes and neurologic localizing signs. The localizing signs are unilateral slight central facial paresis or slight pyramidal syndrome, unilateral absence of abdominal skin reflexes, unequal pupils, change in muscle tone, cortical type of sensory deficiency and pain on pressure or percussion over the temporal bone. Radiography may reveal displacement of the calcified pineal gland away from the side of the lesion. EEG and angiography establish the diagnosis.

(Quoted by World-Wide Abstracts, Vol. 3, No. 3, March 1960.)

SEPARATION ANXIETY. The Psychiatric Bulletin, Vol. 9, No. 4. Fall, 1959.

Three manifestations that the family physician may observe in insecure children are insomnia, so-called school phobia and invalidism. In infants with insomnia, parents must be helped to stabilize the environment for the infant. Regularity in feeding, bathing and bed time will help.

In cases where the child cannot be separated from the parent to go to school, it isn't that the child fears school, but instead fears separation from the mother. Often separation is unwelcome to the mother as well as to the child. Some fear to leave home because a younger sibling will then have unchallenged possession of the mother's attention. In milder cases the general physician should try to get the child to attend school for limited periods during his therapy. The child may then begin to take pride in his being able to stay for longer and longer periods. In some, however, compulsory attendance may be unwise if there is any likelihood of precipitating a more serious illness.

Whether the treatment is conducted by the general physician, or by the psychiatrist, the goal cannot be simply returning the child to school. Some change must be made in the interfamily relationships.

One way that children have of solving their emotional problems is to become ill. In many instances, the mother has encouraged regression. The child's dependency answers the parent's need for security.

The principal cause for neurosis in a child is his living with parents who are neurotic. It is important for the physician to evaluate the family circumstances and interaction if he is to be successful in treating the child.

ENCEPHALITIS AND ENCEPHALOPATHY. Hans Zellveger, Deutsche Mediz. Wochen., 84/43: 1921-25.

The etiology of acute encephalitis may be due to a wide variety of microorganisms, such as helminths, fungi, protozoa, bacteria, rickettsias and viruses, and also toxins, drugs, and exogenous or endogenous antigens. Pseudotumor must be differentiated; also acute cerebellar ataxia due to toxic causes.

During or after many viral or bacterial infections, encephalitis-like conditions may develop. They may also develop after smallpox vaccination, pertussis, rabies, the injection of serum and the ingestion of certain drugs.

Acute demyelination encephalitis may be the result of an antigen-antibody reaction. Toxic vascular encephalopathy may be caused by damage to the vascular endothelium. Ischemic encephalopathy is probably caused by anoxia.

(Quoted by World-Wide Abstracts, Vol 3, No. 3, Mar. 1960.)

PSYCHOLOGICAL FACTORS INVOLVED IN BIZARRE SEIZURES. M. E. Chafetz, M.D., and R. S. Schwab, M.D. Psychosom. Med., 21:96-105, March-April 1959.

The authors report on 20 patients whose seizures required extensive neurologic and psychiatric study. It was found that marked psychological difficulties existed prior to the onset of the seizures; the seizures were often used to control the environment and frequently occurred in clusters during periods of extreme tension.

In most instances the EEG findings were equivocal; the response to anticonvulsants was unpredictable. The authors feel that these patients can best be treated by a team approach, utilizing both the neurologist and the psychiatrist, since the patient can make use of physical needs as a defense against psychiatric exploration.

PHYSIOLOGIC, PSYCHOLOGIC AND SOCIAL DETERMINANTS OF PSYCHOSOMATIC DISEASE. I. A. Mirsky, M.D., Dis. of the Nerv. System, Vol. 21, No. 2, Sect. 2, pg. 50-56, Feb. 1960.

Psychosomatic medicine developed as a hybrid —the result of the convergent approaches represented by Cannon and Freud. When viewed as another branch of medicine, it is sterile—but when seen as a method whereby tools and concepts of the behavioral sciences are integrated with those of the other disciplines, it has vigor. Psychosomatic does not mean psychogenic—nor does it imply the absence of a genetic determinant.

Gastric hypersecretion is an essential but not the sole cause of duodenal ulcer. Patients with this illness exhibit strong infantile, oral, dependent wishes. They also have tendencies to please and placate, yet similar patterns can be demonstrated in subjects without ulcers. Some sociocultural event is a major factor in the precipitation of duodenal ulcer; it is not the situation itself, but the specific meaning of the event to the particular individual that determines the response.

The high familial incidence of duodenal ulcer and the greater incidence of blood group type O among these patients suggest some genetic factor.

Studies indicate three parameters which contribute to the development of duodenal ulcer: 1) physiological—gastric hypersecretion; 2) psychological—specific psychological conflict; 3) social—an environmental event which will prove noxious to the particular individual.

The rate of gastric secretion with which a child is born may of itself play a significant role in the relationship between mother and child. In the infant with gastric hypersecretion, even a normal rejecting mother may be only partially successful in meeting the infant's needs for physiological satiation which in turn permits the infant to pass successfully through the earliest phases of emotional and social development. In the degree in which these needs fail to be met, subsequent environmental events are perceived as noxious ones in terms of persistent infantile needs.

URINARY EXCRETION OF PHENOLIC ACIDS BY NORMAL AND SCHIZOPHRENIC MALE PATIENTS. J. D. Mann and E. H. LaBrosse. A.M.A. Arch. Gen. Psychiat., 1:547-551, 1959.

The excretion of phenolic acids was studied and found to be different for schizophrenics as compared to normal males. Since these same compounds had been reported as metabolic products of substances present in coffee, the authors studied the correlation between the findings and the coffee-drinking habits of their patients. Their findings indicated that the excretion of these acids correlated significantly with the coffee intake. It is apparent that a careful search for uncontrolled variables is necessary. This is especially needed because of the high sensitivity of paper chromatographic methods to variations in the diet.

ESTROGEN AND PSYCHOSEXUAL DISORDERS. L. H. Whitaker, M. J. Australia, 2:547-549, Oct. 1959.

The author reports that it has been routine practice to administer large doses of estrogen prior to surgery in adult males who are to be circumcized so that an inhibition of the erectile mechanism can occur. It is also reported that the use of estrogens in preventing orchitis after infectious parotitis results in impotence which lasts for weeks. These observations prompted the treatment of patients with psychosexual disorders. The group included patients with homosexuality, abnormally powerful heterosexual drives and exhibitionisms. Stilbesterol was given by mouth in dosage of 5 mg. for two weeks to produce complete inhibition; where it was desired to merely reduce the intensity of the sexual drive, the dose was 1 mg. daily until the reduction was noted by the patient. The results indicated that this form of treatment can control but cannot cure the deviation of aim or object of the sexual drive. The author stressed the need for repetition of the treatment at intervals.

CEREBELLAR ATAXIA. S. Weiss and S. Carter. Neurology, 9:711, 1959.

Records of patients under 17 years of age with acute cerebellar ataxia were reviewed. Non-specific infectious disease often precedes the sudden onset of severe gait ataxia. Other initial signs include tremor of the trunk or extremities, abnormal eye movements and myoclonic or tic movements. In 6 of the 18 patients studied, neurologic abnormalities persisted during the follow up period of 9 months to 6½ years. In the majority of patients complete recovery occurs within six months with no evidence of neurologic defect.

W.D.

Book Reviews

LET YOUR MIND ALONE. By James Thurber. New York: Harper and Brothers. $1.25, 245 pgs.

In this era of "streamlined thinking," the needs for efficiency and materialism demand that we operate and conduct our thoughts, attitudes and behavior with discipline and determination. This book is a definite protest to this sort of thing and gives "cheer" and hope to those of us who haven't quite made the grade.

It seemed to this reviewer that the essence of the author's thesis is akin to what doctors try to do with their over-conscientious, perfection-seeking patients, i.e., to get them to realize that they are human beings—with all the fallibility, human error and miscalculation that goes along with the human state. *Let Your Mind Alone* cannot be expected to replace standard textbooks in psychiatry and psychoanalysis; nor can it be considered as evidence of another revolution from the influence of Freud. (I am certain that its author would be aghast at any of these possibilities.) However, it does read a lot easier than any of these standard texts. It unfortunately cannot be recommended for those preparing for board examinations in psychiatry, but it most definitely is a delightful diversion for those who spend a good deal of their time in not "letting minds alone."

Mr. Thurber has definite opinions about the many "success experts" who write books on the "Science of Happiness," "The Technique of Thinking," "Streamlining Your Mind," "Be Glad You're Neurotic," etc., etc. His case studies illustrate the problems involved in carrying out their detailed instructions; they cannot be abstracted here because they will too easily divert the reader from the rest of *Psychosomatics*. The contributors to this journal just can't match this material. Nobody sees the cases that Thurber sees; if they do, they just don't have the guts to get them published.

In "A Dozen Disciplines," a particularly succinct exposition of "psychological associations," the author proves that it is not within everyone's grasp to "Wake Up and Live 24 Hours a Day," as outlined by Dorothea Brande. He illustrates the difficulties involved in sustained concentration with ample case material and points up the crushing though clinical observation that there are problems involved in planning to "live even two hours a day."

In a chapter entitled "Anodynes for Anxieties," Mr. Thurber exposes the fallacies of David Seabury's "How to Worry Successfully." He does admit, however, that "when things get really tough he always turns to one particular section and reads through it twice, the second time backward." Unfortunately, he doesn't mention the reference.

In "The Conscious vs. The Unconscious," a lucid review of "Be Glad You're Neurotic" by Dr. Louis Bisch is offered. Here we see a critical re-evaluation of some of the conflicts, obsessions, compulsions and other deviant behavior illustrated by Dr. Bisch. In one of these, Thurber actually gets one up on the distinguished doctor when his penetrating analysis of Dr. Bisch's analysis proves beyond any question of doubt that "psychiatrists are just as afraid of their wives as anybody else." Dr. Bisch apparently missed this because of his own blind spots, but Thurber sure picked it up. In his conclusion to this chapter, the author states that if "he were a psychiatrist he wouldn't bother with some of the cases mentioned by Dr. Bisch." This is a debatable point, since very few psychiatrists can hand-pick their material, and I doubt if Thurber would really be too choosy, judging from some of his case studies. Perhaps, in defense of both Dr. Bisch and Mr. Thurber, if these patients would have "let their minds alone," they would have then let the doctor alone; he in turn would have let the patients alone and Thurber would let Bisch alone.

"Sex Ex Machina" points up Thurber's basic orientation, which seems to be somewhat Freudian, although he would be the last to admit it. For instance, he cannot accept the fact that "an automobile bearing down upon you may be a sex symbol," but let's face it—it came to Thurber's mind before it was rejected. He would much rather think of it as "a real automobile—especially if it occurs in the waking state." One gets the impression that it may be extremely difficult at times to know when Thurber is in a "waking state." Here is one instance where the conscious and unconscious are not too well demarcated, but definitely on friendly terms.

All in all, this book is a refreshing, illuminating study of the human mind, although it is seen from a distinctly different frame of reference and discipline. Although Thurber would probably shudder at the very thought that he might represent any type of discipline, it is certain that his sense of humor would easily absorb the shock.

(Permission was granted the author by the publishers and Mr. Thurber to quote from this book.)

W.D.

NEUROPHARMACOLOGY. Transactions of the Fifth Conference, May 27, 28, and 29, 1959, Princeton, N. J. Harold A. Abramson, M.D., Editor. New York: Josiah Macy, Jr. Foundation, 1960. 251 pages. $6.00.

This book is the transcription of the Fifth Conference on Neuropharmacology, which was held in 1959, and is essentially a stenographic report of the comments of the twenty-eight participants. There is a brief introduction, followed by four conferences, at which the following subjects were discussed: "Amine Metabolism and Its Pharmacological Implications," "Central Action of Chlorpromazine and Reserpine," "Physiological Fractionation of the Effect of Serotonin on Evoked Potentials," and, "Biochemical Sites of Action of Psychotropic Drugs," at the end of which there is a summation by Carl C. Pfeiffer of the Department of Pharmacology, Emory University School of Medicine, Atlanta, Georgia. He states on page 235 that:

"1) Neither chlorpromazine nor reserpine have a *direct* effect on the functioning of the reticular formation.

"2) Both chlorpromazine and reserpine augment the effect of peripheral stimulation (input) on the reticular formation.

"3) Most of the phenomena which have hitherto been ascribed to the direct action of chlorpromazine and reserpine on the reticular formation are possibly the result of changes in anterior, posterior, and lateral input.

"4) Reserpine, in contrast to chlorpromazine (in doses where both inhibit the conditioned avoidance response) has a more profound effect in disorganizing the fundamental processes which control behavior."

This book is certainly not for the general medical reader but would be of distinct value to anyone concerned with the effect of the new psychopharmaceuticals.

James L. McCartney, M.D.
Garden City, N. Y.

TALKING WITH PATIENTS. By Brian Bird, M.D. Philadelphia, Pa.: J. B. Lippincott Co., 1955. 153 pages.

Among the items which might be listed as "things I didn't learn in medical school," this reviewer would include the technique of interviewing or just plain talking with patients. Among non-psychiatrists one suspects there are many others similarly situated. For those of us in this particular situation, this book is helpful. The author, Associate Professor of Psychiatry at Western Reserve University, describes many of the types of patients encountered in everyday office practice, which vary from the crying child to the overly affectionate adult, and tells the reader how to talk with them. The book is succinct, clear, and characterized by a common sense approach. It should be in the library of every physician who has not had special training in interview techniques.

F. W. Goodrich, Jr., M.D.
New London, Conn.

PSYCHOPHARMACOLOGY — PROBLEMS IN EVALUATION. (Proceedings of a Conference sponsored by the National Institute of Mental Health, the National Research Council and the American Psychiatric Association). Edited by Jonathan O. Cole, M.D., and Ralph W. Gerard, M.D. Published by the National Research Council, 2101 Constitution Ave., Washington, D.C., 1959. 662 pages. $6.50.

This long awaited book, finally published in 1959, although based upon a conference held in September 1956, is a vibrant, lucid and excellent report on the problems of evaluation of the newer mental drugs. At this conference, the techniques, developments and problems of varied disciplines were ventilated, resulting in a manuscript which should be required reading for all who do drug research and for all who attempt to interpret the results of such research.

In Section I, entitled "General Review Papers," of special interest were: "The Pharmacological Aspects of Certain Drugs Useful in Psychiatry," by Eva Killam; "Animal Experimental Studies" by Joseph V. Brady; "Problems Involved in the Study of Drug-Modified Behavior in Normal Humans" by Lasagna and Laties; and "The Evaluation of Effectiveness" by J. O. Cole.

In Section 2, entitled "Preliminary Screening," of special value were: "Neuropharmacological Research" by Killam and Killam; "Commentary on Electrophysiological Techniques" by J. E. P. Toman; "Biochemical and Enzymatic Considerations" by James A. Bain; "The Loci and Mechanisms of Action" by Abraham Wikler; "Animal Research" by B. F. Skinner; "Animal Behavioral Studies" by Joseph V. Brady and Howard F. Hunt; "The Relevance of Animal Studies to Man" by Edward V. Evarts; and "Clinical Assessment" by Harris Isbell.

In Section 3, entitled "Test Conditions," of special interest were: "Socio-psychological Factors" by Morris S. Schwartz and "Drug Research Design in a Psychiatric Out-Patient Setting" by David Rosenthal.

In Section 5, entitled "Evaluation," most interesting was: "Biochemical and Physiological Changes in Schizophrenia" by Edward F. Domino.

In Section 6, entitled "The Main Conference,"

each section summarized its findings for the entire group. Most interesting was the free, open and frank discussion in which so many participated with no holds barred.

Most valuable is that this study cuts across all disciplines. Although some discussants at times felt that their own particular discipline and approach was the only one that really did matter, for the most part there was definite evidence of real tolerance and a willingness to learn about the other fellow's problems. The difficulties and complex problems of research design and the many pitfalls in the interpretation of results were adequately considered and discussed.

This book, despite the fact that it may appear to be ancient history in a rapidly developing area such as psychopharmacology, is heartily recommended as an authoritative and surprisingly up-to-date summary of existing knowledge in this field. It is a book that will add new dimensions to the perspective of the reader, whether his basic orientation is animal research or the disturbed patient who is in need of his doctor's help.

W.D.

AND BEAT HIM WHEN HE SNEEZES. By Stanley & Janice Berenstain. New York: McGraw-Hill, 1960. 128 pages. $2.95.

These two Philadelphia married (to each other) cartoonists based a good part of this extremely humorous and tastefully satirized version of pregnancy, labor, "natural" childbirth and the first forty months of child development on the natural antics of their two sons.

The captions on the cartoons are amusing and realistic. The expressive cartoons themselves are hilariously interpreted in the light of the modern parent's training and experience.

This easily read book is a welcome relief to the serious student of the psycho-physiological development of the human individual from its earliest beginnings.

Leo Wollman, M.D.
Brooklyn 24, N. Y.

PSYCHOPHYSIOLOGIC APPROACH IN MEDICAL PRACTICE. By William W. Schottstaedt, M.D. Chicago: The Year Book Publishers, Inc., 1960. 352 pages. $8.00.

During the last few years, there has been an increase in the number of psychiatric courses given both at an undergraduate and a graduate level. Emphasis has been placed on giving the general practitioner a better understanding of the interrelationship of the psyche and the soma. This book is certainly directed towards that end. As pointed out in the preface, it is "written primarily for medical students, interns, residents, and practicing physicians who are interested in psychophysiologic phenomena but who do not expect to have formal psychiatric training." The thirteen chapters cover the subject well, as indicated by the titles: "Stress," "Physiologic Mechanisms," "Mental Mechanisms," "Emotions," "Social and Cultural Forces," "Constitution and Conflict," "Reaction to Illness," "Interviewing," "Doctor-Patient Relationship," "Dealing with Emotions," "Defenses in Treatment," "Social Forces and Conflicts," and "Course of Treatment." The author's approach is logical and systematic and is not oriented to any one school of thought.

As pointed out by the author, the emotions affect most illnesses, or most illnesses affect the emotions, and many of these emotional disturbances do "not require psychiatric care if the internist or general practitioner felt at ease in using a few basically simple psychotherapeutic techniques." In understanding these problems it is necessary to realize that "the mechanisms which account for fluctuations in the course of 'psychosomatic diseases' are the same as those which are associated with fluctuations in the course of diseases in general and are again the same mechanisms as those resulting in the whole gamut of 'functional' complaints." In chapter three, these mental mechanisms are discussed in detail, and, as the author states, different writers list these mechanisms differently. The ones which he discusses are: "gratification, suppression or inhibition, avoidance, displacement (including sublimation), reaction-formation, denial and repression, and identification."

Throughout the book, the author illustrates each point with case histories, and on page 323 he discusses psychotherapy by the practitioner and states that "psychiatric referral is necessary for only a small percentage of the patients seen in general practice. Many others have situational stresses and emotional problems which are pertinent to their physical symptoms, however. As one questions the patient about his symptoms and their relationship to eating, exercise, or other activities, he should also ask about the situation in which they arose. Identification of stressful situations, evaluation of the relative importance of different aspects of these situations, and full delineation of the patient's responses to them is usually not too difficult when these questions are posed in the context of the presenting complaints." He finally ends the whole book with the sage remark: "Physicians affect the lives of their patients whether they wish to or not. If they use their influence to help others meet the stresses to which they are exposed effectively, much unnecessary suffering can be avoided. The influence spreads out in ever-

widening circles as each of these alters his reactions to others. Physicians should be prepared to relieve mental anguish as well as the physical symptoms which may accompany it and should strive to help those who come to them become happier and more effective people."

This book lists ninety-six references which may be used for supplementary reading, and the volume is well indexed. This discussion can be most heartily recommended for any physician or surgeon who wishes a better understanding of psychosomatic interrelationships. It is clearly written, without technical verbiage.

James L. McCartney, M.D.
Garden City, N. Y.

HYPNOSIS IN ANESTHESIOLOGY. By Milton J. Marmer, M.D. Springfield, Ill.: Charles C. Thomas, 1959. 150 pages. $6.95.

Any book with "hypnosis" in the title is apt to attract the attention of only a restricted, albeit an increasing number of physicians. When the title is further qualified by the words, "in anesthesiology," the field of interest may be even more limited. This is extremely unfortunate, since Dr. Marmer, the Chief of Anesthesiology at Cedars of Lebanon Hospital, Los Angeles, California, has written an intensely practical manual which can be read with profit by any practising physician, whether he overtly practices hypnotherapy or not. Dr. Marmer's empathy and understanding is evident throughout, and his techniques for handling anxiety are pragmatically sound. He stresses the point that the use of deep hypnosis for surgery is not always practical; the induction of hypnoidal or light trance states as a preparation for anesthesia is extremely valuable, easy, consumes little time, and should be utilized as often as possible. "Ideal anesthesia combines hypnosis with reduced doses of chemical agents." This approach, helpful during surgery, enhances the comfort and confidence of the patient.

Dr. Marmer describes in full his techniques for inducing hypnosis and gives case reports demonstrating its applications in varied situations.

Any doctor who does minor or major surgery, anesthesia, or obstetrics, will find this book an extremely valuable addition to his library, whether or not he purports to use hypnosis.

Frederick W. Goodrich, Jr., M.D.
New London, Conn.

MEDICAL TREATMENT OF MENTAL DISEASE. D. J. McCarthy, M.D., and K. M. Corrin, M.D. Philadelphia: J. B. Lippincott Co., 1955, 653 pages.

The theme of this book is the concept of a toxic or organic basis for a vast majority of mental diseases—that the mental patient is a medical problem rather than purely a psychological one.

The authors review the evidence for the physical basis of psychiatry. The causes of mental disorders are considered to be multiple, inclusive of congenital, chemical, pathologic, physiologic and psychologic factors. Significant to this reviewer is the statement that "the psychiatrist should be an expert internist."

Despite the predominantly organic orientation given to the various mental diseases discussed, there is nevertheless displayed a keen insight and knowledge of psychodynamics. Psychotherapy is not neglected, but is seen as an adjuvant to good comprehensive medical treatment. Psychoanalysis is visualized as "probably destined for many changes . . . its greatest contribution to medicine will be the large number of expert psychotherapists it will produce who will avoid the dogma and isolation of orthodox psychoanalysis to become fully trained clinical psychiatrists."

The chapters on psychophysiological disorders are especially valuable, since their presentation includes a discussion of both the physiological as well as the psychological factors involved. Multiple factors in the etiology, pathogenesis and treatment of the various disorders are constantly emphasized.

This book is valuable to both the non-psychiatrist as well as the psychiatrist. To the former it will make psychiatry more intelligible and acceptable. To the latter, it will provide a better insight of the psychiatrist's broader role as a scientific physician.

W. D.

To Those Receiving This Journal as a Complimentary Copy:

This will introduce you to PSYCHOSOMATICS, the official journal of the Academy of Psychosomatic Medicine. This is a brand new publication focusing on an area of rapidly growing significance: the role of psychiatry in the daily practice of medicine. As a journal written for the medical profession generally rather than the psychiatric specialty specifically, PSYCHOSOMATICS will bring you pertinent, readable papers by physicians in all areas of medicine, keyed to the theme of treatment of the "total patient." In addition, for the busy practitioner there are reviews of books and abstracts of articles drawn from the entire medical literature. On the next page you will find the titles of a few of the papers scheduled for publication in subsequent issues. If you do not presently receive PSYCHOSOMATICS regularly you will certainly want to send in one of the coupons shown below.

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Listed below are a few of the articles that will appear in subsequent issues of *Psychosomatics*.

PRURITUS AS A SYMPTOM OF DEPRESSION

Samuel I. Greenberg, M.D.

CHEST PAIN OF CORONARY ORIGIN

Burton L. Zohman, M.D.

PSYCHOSOMATIC INFERTILITY TREATED BY MEDICAL HYPNOSIS

Leo Wollman, M.D.

THE USE OF GROUP THERAPY BY THE NON-PSYCHIATRIC PHYSICIAN

Victor J. LoCicero, M.D.

SOMATO-PSYCHIC ASPECTS OF COSMETIC SURGERY

Louis J. Feit, M.D.

PROBLEMS AND PITFALLS IN CLINICAL PSYCHOPHARMACOLOGY

Douglas Goldman, M.D.

PSYCHOTHERAPY OF MIGRAINE BY THE NON-PSYCHIATRIST

Dezso Levendula, M.D.

THE PSYCHIATRIST AND THE GENERAL HOSPITAL STAFF

Milton Kurian, M.D.

THE BROOKLYN PROJECT FOR THE PSYCHIATRIC INDOCTRINATION OF NON-PSYCHIATRIC PHYSICANS

Matthew Brody,, M.D., Morton M. Golden, M.D., and Harry S. Lichtman, M.D.

EMOTIONAL PROBLEMS IN SURGERY: POINT OF VIEW OF THE G.P.

Bertram B. Moss, M.D.

COMPREHENSIVE PSYCHOTHERAPY

Jules Masserman, M.D.